Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for a Renewal to a §1915(c) Home and Community-Based Services Waiver

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:
Kansas recently amended the waiver application to include the new quality measures in order to comply with CMS requirements. Kansas is submitting a renewal of HCBS/PD program requesting CMS approval for modification to the brief description and the following changes to the program:

1) KDADS has developed a transition plan for the HCBS/PD settings that will assess and ensure Kansas provider settings meet the requirements of the HCBS Final Setting Rule within 5 years.

2) Kansas has contracted with Kansas University (KU) to evaluate the current assessment instrument in comparison to other States to identify an assessment instrument with demonstrated reliability and validity. The purpose of this contract is to develop a standardized eligibility assessment to assess level of care eligibility for all HCBS populations served by Kansas programs. Following final decision of a statewide eligibility assessment instrument, Kansas will develop a work plan to implement a phase in assessment process to include dual assessment using the current assessment tool and the new statewide assessment instrument in order to evaluate outcome. Kansas anticipates a phase-in implementation of the new statewide assessment instrument to begin by 01/1/15.

3) Kansas clarified the Managed Care Health Plans roles and responsibilities for service plan development in Appendix D-1 to be consistent with pre-KanCare State practices.

4) Kansas is proposing a change in service definition for Financial Management Services (FMS), a draft proprosal has been submitted to CMS for review and input.

5) Changes to the projected numbers of unduplicated individuals served for each year of the renewal

6) Kansas has made general language changes from individual, consumer, or beneficiary to participant to be consistent with CMS language and Aging and Disability Resource Center (ADRC) to contracted assessor to be consistent across all programs. Kansas has also made general language changes from Functional Assessment Instrument (FAI) to Functional Eligibility Instrument (FEI).

7) KDADS has made general grammatical changes or corrections throughout the waiver from Appendix A to Appendix J, as needed.

8) Removed language that does not apply to the HCBS/PD waiver and was placed in error, including references to the HCBS/TBI program.

9) Participants receiving services on the HCBS/PD waiver will now be required to transition to the HCBS/FE waiver once they reach age 65, for those turing 65 after 01/01/2015. Participants who are age 65 or older prior to 01/01/2015 may elect to transition to HCBS/FE or may also choose to remain on the HCBS/PD waiver if they so choose.

10) The State continues to consult with the US Department of Labor on the applicability of the DOL's new interpretation of the companionship exemption on Kansas self-directed programs. The DOL has delayed its enforcement of the rule by six months (to July 1, 2015).

11) The State has reserved capacity for military personel entering into HCBS/PD services.

12) The state has reserved capacity for participants who have gone into a skilled nursing facility or hospital for a temporary stay. This allows participants who have moved into a facility temporarily to have their position on the program reserved while until their temporary stay ends.

13)Proposed Language Applicable to All HCBS Services For the Purpose of Mitigating Conflict of Between Guardian and Consumer.

Kansas mitigates potential conflict of interest and ensures that the guardian being paid as the provider and developing the plan of care with MCOs is in the best interest of the consumer. The following assurances are proposed to mitigate potential conflicts between the role of guardian, legal guardian, durable power of attorney, and other legally responsible individuals (consistent with KAR 26-41-101 and KAR 26-42-101) directing the plan of care and the guardian as a paid care giver of services for the participant.
a. The home and community based services final rule prohibits providers of 1915(c) waiver services and those with an interest in or employed by a provider of HCBS services from developing the person-centered services. Since the individuals or entities responsible for person-centered plan development must be independent of the HCBS provider, a legal guardian, durable power of attorney, and other legally responsible individuals who receive payment for providing HCBS may not be responsible for development of the person-centered plan.
b. Court-appointed legal guardians of adults receiving Medicaid-funded home and community based services must comply with state law regarding guardianship and reporting of potential conflicts of interest to the court (K.S.A. 59-3068). If a conflict of interest exists, legal guardians of adults receiving Medicaid-funded home and community based services must designate a representative to direct the services of an individual the guardian provides supports to and represents. Annually, the legal guardian will provide the State or designee with a file-stamped copy of the special or annual report in which the conflict of interest is disclosed.
c. Care coordinators and financial management service providers who identify situations in which a conflict of interest exists must provide information to the individual and the legal guardian to address the conflict. This action will allow legal guardians to address conflict of interest, while retaining the right to be a paid care provider.
d. An exception to the criteria may granted by the State when a participant/ guardian lives in a rural setting and the nearest agency-directed service provider available to provide services is in excess of 50 miles from the participant residence; or
e. CMS provides an exception to this rule if there is only one willing and qualified provider in a geographical area who provides HCBS, case management, and develops the person-centered plan. However, in these situations, the state must develop conflict of interest protections to separate provider functions and obtain approval from CMS. In additional, individual recipients of services must have an alternate dispute resolution process available.

14)Proposed Language Applicable to All HCBS Services For the Purpose of Mitigating Other Conflicts of Interests
Providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual must not provide case management or develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS. In these cases, the State must devise conflict of interest protections including separation of entity and provider functions within provider entities, which must be approved - 42 CFR §441.301 (b)(1)
In general, an HCBS provider, its employees and related entities, cannot provide service planning or case management for the beneficiary. HCBS state-plan services require conflict of interest standards and safeguards.

At a minimum, assessor, case manager, and agent determining eligibility cannot be:
1. Related by blood or marriage to the consumer;
2. Related to any paid service provider for the consumer;
3. Financially responsible for the consumer;
4. Empowered to make the consumer's financial or health related decisions; or
5. Hold a financial interest in any entity paid to provide "care" for the consumer.
If the only willing and qualified provider in a rural area provides case management, and develop the person-centered service plan, also provides direct services, the state will ensure administrative firewalls are present. The State will ensure the

following:
• The agency does not case manage the clients to whom it provides services.
• The governing structure is transparent with stakeholder involvement.
• Staff should not be rewarded or penalized based on care planning results.
• Case management functions and direct service provision are separated
• Agency should have a conflict of interest policy available for consumers
• Agency should have and maintain a participant complaint system and track and monitor complaints that are reported to the State

The State will ensure policies, processes and protocols are in place to that directs and supports the person-centered planning process and mitigates potential conflicts of interests

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The **State of Kansas** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. **Program Title** (*optional - this title will be used to locate this waiver in the finder*):
Kansas Physical Disability Waiver

C. **Type of Request: renewal**

Requested Approval Period: *(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **3 years** ◎ **5 years**

Original Base Waiver Number: KS.0304
Draft ID: KS.014.04.00

D. **Type of Waiver** *(select only one):*
Regular Waiver

E. **Proposed Effective Date:** *(mm/dd/yy)*
01/01/15

1. Request Information (2 of 3)

F. **Level(s) of Care.** This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (*check each that applies*):

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**
If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☑ **Nursing Facility**

Select applicable level of care

◎ **Nursing Facility as defined in 42 CFR □□440.40 and 42 CFR □□440.155**
If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:
N/A

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☐ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**
If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities
Select one:

- ○ **Not applicable**
- ◉ **Applicable**

Check the applicable authority or authorities:

- ☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**
- ☐ **Waiver(s) authorized under §1915(b) of the Act.**

  Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

  Specify the §1915(b) authorities under which this program operates *(check each that applies):*
  - ☐ **§1915(b)(1) (mandated enrollment to managed care)**
  - ☐ **§1915(b)(2) (central broker)**
  - ☐ **§1915(b)(3) (employ cost savings to furnish additional services)**
  - ☐ **§1915(b)(4) (selective contracting/limit number of providers)**
- ☐ **A program operated under §1932(a) of the Act.**

  Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:
- ☐ **A program authorized under §1915(i) of the Act.**
- ☐ **A program authorized under §1915(j) of the Act.**
- ☑ **A program authorized under §1115 of the Act.**

  Specify the program:
  KanCare 1115 Demonstration Project

H. Dual Eligiblity for Medicaid and Medicare.
Check if applicable:

- ☑ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.
The purpose of the Kansas Physical Disability (PD) waiver is to provide eligible Kansans the option to receive services in their home and community rather than in a more expensive, less-integrated nursing home setting. PD services are available to individuals who are between the minimum age of 16 years and the maximum age of 64 years, and who are financially eligible for Medicaid. Individuals must also meet the minimum PD threshold score on a functional assessment conducted by an Aging and Disability Resource Center (ADRC) acting as the State's designee. Participants are annually reassessed by an ADRC to determine if they continue to meet the level of care.

Services available through the PD waiver are: assistive services, financial management services, home-delivered meals, medication reminder services and installation, personal emergency response system and installation, personal services (self-directed and agency-directed), and sleep cycle support.

With this amendment, PD waiver services will be provided as a part of a comprehensive package of services provided by KanCare health plans (Managed Care Organizations), and will be paid as part of a capitated rate. The health plans are responsible for assigning a case manager who will conduct a comprehensive needs assessment and develop a person-centric plan of care that includes both state plan services and, as appropriate, the PD services listed above.

The move to integrate PD waiver services into KanCare does not diminish the waiver's focus on independent living and consumer-driven services. Consumers will continue to have a choice between consumer-directed (self-directed) services whereby they choose their personal care attendants, or they may choose agency directed (non-self-directed) services using licensed home health agency staff as personal care attendants.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. **Waiver Administration and Operation. Appendix A** specifies the administrative and operational structure of this waiver.

B. **Participant Access and Eligibility. Appendix B** specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. **Participant Services. Appendix C** specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. **Participant-Centered Service Planning and Delivery. Appendix D** specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

E. **Participant-Direction of Services.** When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- (◉) **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ( ) **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. **Participant Rights. Appendix F** specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. **Participant Safeguards. Appendix G** describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

H. **Quality Improvement Strategy. Appendix H** contains the Quality Improvement Strategy for this waiver.

I. **Financial Accountability. Appendix I** describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. **Cost-Neutrality Demonstration. Appendix J** contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. **Comparability.** The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B.**

B. **Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- ( ) **Not Applicable**
- ( ) **No**
- (◉) **Yes**

C. **Statewideness.** Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- (◉) **No**
- ( ) **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.
Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.
Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

A. **Health & Welfare:** The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C.**

B. **Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I.**

C. **Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B.**

D. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,
2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. **Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would

have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. **Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. **Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. **Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. **Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. **Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. **Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. **Inpatients.** In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in -patients of a hospital, nursing facility or ICF/IID.

C. **Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. **Access to Services.** The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. **Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. **FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those

served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. **Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. **Quality Improvement.** The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H.**

I. **Public Input.** Describe how the State secures public input into the development of the waiver:
Tribal notice was sent as required within 60 days to inform tribal leaders, information regarding this renewal was offered in person and by phone in August 2014.
Kansas offered various opportunities for securing public comments regarding the proposed work plan in response to the HCBS Settings Final Rule. The draft transition plans were posted online and a 30 day comment period was open between June 14, 2014 and July 15, 2014. Opportunities were provided through statewide conference calls and in-person public information session held in (Lawrence, Topeka, Wichita) during the week of June 16-23, 2014. Additionally, the public was invited to submit comments through the HCBS general email address (HCBS-KS@kdads.ks.gov)or by mail. The purpose of the sessions was to meet two primary objectives:
1)To meet requirements for public comment period on the HCBS transition plan 2)To listen to comments from the public, record the comments,and submit a summary with the transition plan to CMS.
Format for each session: Wichita State University Center for Community Support and Research (CCSR) staff opened the meeting, logistics. KDADS state staff presented background information and draft transition work plan, including information regarding providers self-assessment surveys (due June 30). KDADS staff provided handouts on the statewide transition plan, HCBS Final Rule and FAQs relating to the final rule. The facilitator, CCSR ask the following questions in each public sessions and conference call and provided opportunities for attendees to dialogue with each other in small groups, while KDADS listened to the discussions.
•What questions or understanding or clarification do you have? •Related to the rule you just heard about, what is already working in Kansas? Where are we already complying? What do you like about home and community based settings? •Based on what you heard today, what concerns do you have? What might need to be changed or improved to come into compliance with the rule? What do you think our biggest compliance issues will be? •What other types of settings should the state consider? •What other questions should the state be thinking about?
Comments are grouped by date and session type. CCSR collected general comments and confirmed attendees understanding of information being presented. Comments from a single person that covered multiple issues may have been divided into categories of facilitated questions as noted above; however, written comments are included verbatim. Comments received in-person has been paraphrased by the facilitator and by confirming with the person making comments the information was captured correctly.The conferencing and in-person sessions attendance was well represented by providers from various settings such as long-term care facilities, group homes, private ICF-ID, other interested stakeholders and advocates. Kansas hosted an additional week long public information session statewide during the week of August 18-22, 2014 to recap the HCBS Setting Final Rule. This additional public comment session also requested consumer and stakeholder feedback on the Department of Labor Rule, and proposed waiver amendments (Autism and Technology Assisted) programs and renewals (Frail Elderly, Intellectual Developmental Disability, Physical Disability and Traumatic Brain Injury) programs to be submitted 9/30/14. In these sessions, Kansas provided a short summary of the HCBS Final Rule, the transition plan and what it means to consumers. The session was well attended by many HCBS consumers and family members, the overall message regarding the HCBS final rule and the transition plan was well received by the majority. Consistently, Kansas heard consumer, family and provider concerns/ comments relating to the following examples:•Will every setting receiving HCBS funding be assessed?•Is the state expecting further guidance on person-centered planning and conflict-free case management?•Do other settings where people go have to come under the HCBS final rule guidelines? Like the YMCA, or a cruise ship. Do those settings have to come into compliance? •In a group home, does the "able to lock their own door" part apply to the whole house, or each individual?•It might not be safe for every individual to be able to lock themselves behind a closed door. Will provision be made for those exceptions?•Where it says that

individuals should be able to access communication through text message and email, is it expected that providers would provide those tools, or that the individuals would?•Where do we see this final ruling affecting individuals who live in group homes? They've lived there for 15-20 years; this is a family for them. They have a few hours of independent time during the day. Is this something where we're going to have to encourage them to move?•How vulnerable is too vulnerable to live alone in the community?•Do all waivers have a full 5 years to get in compliance? Some appear to have only 12 months. Kansas will assess settings and may request 5 years for transitions. The public feedback sessions provided Kansas with valuable information as we move into the next phase of the transition plan. Following the additional public comments sessions, Kansas will need to explore possible options to allow exceptions for individuals where the HCBs setting may be assessed out of compliance with the final rule and moving to an alternative setting may threaten the health and welfare of the person. The facilitator (CCSR) collected and summarized the comments and information from in-person meetings, teleconferencing, and by email and provided a themed summary. The feedbacks have been reviewed and are ready to be incorporated into the waivers for submission by September 30th.
All public session opportunities related to the HCBS Final Rule, DOL Final Rule, and proposed amendments and renewals along with the public comments are available on the KDADS website at www.kdads.ks.gov

J. **Notice to Tribal Governments.** The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. **Limited English Proficient Persons.** The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name: Graff-Hendrixson

First Name: Bobbie

Title: Senior Manager, Contracts, State Plans and Regulations

Agency: Kansas Department of Health and Environment

Address: Landon State Office Building, Room 900N

Address 2: 900 SW Jackson Street

City: Topeka

State: Kansas

Zip: 66612-1220

Phone: (785) 296-4109 **Ext:** ☐ **TTY**

Fax:

E-mail: (785) 296-4813

BGraff-Hendrixson@kdheks.gov

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name: DeCoursey

First Name: James

Title: PD Program Manager

Agency: Kansas Department for Aging and Disability Services/Community Services & Programs

Address: New England Building

Address 2: 503 S. Kansas Avenue

City: Topeka

State: Kansas

Zip: 66612-1570

Phone: (785) 296-4980 **Ext:** ☐ **TTY**

Fax: (785) 296-0557

E-mail: jim.decoursey@kdads.ks.gov

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.
Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature:

State Medicaid Director or Designee

Submission Date:

Last Name: **Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.**

First Name:

Attachments

Mosier

Title:

Attachment #1: Susan

Agency:

Transition Plan M.D., Medicaid Director, Director of Health Care Finance

Address:

Specify the transition plan Kansas Department of Health and Environment

Address 2:

for the waiver: 900 SW Jackson Ave., Suite 900

City:

The integration of PD

State:

waiver services into Topeka

Zip: **Kansas**

Phone:

KanCare health plans will take effect January 1, 66612

Fax:

2013, with the (785) 296-0149 **Ext:** ☐ **TTY**

implementation of

E-mail:

KanCare. The change is limited to the (785) 296-4813

delivery system. There is no change in

eligibility for the

waiver services or the smosier@kdheks.gov

scope and amount of services available to waiver participants. Beneficiaries who are American Indians and Alaska Natives will be presumptively enrolled in KanCare, but they will have the option of affirmatively opting-out of managed care.

The State's plan for transition of PD services to KanCare is multi-pronged:

1. Beneficiary Education and Notification; Targeted Readiness for HCBS Waiver Providers. The State has conducted extensive outreach to all Medicaid beneficiaries and providers regarding the integration of PD waivers services into KanCare. There have been five rounds of educational tours to multiple cities and towns across the state since July 2012. These tours generally included daily sessions for providers and daily sessions for beneficiaries (and usually included two different beneficiary sessions in the day – one earlier in the day and one later in the day to accommodate a wide range of schedules). Two of these tours were for all KanCare beneficiaries and providers; one focused on dental providers; and one was specifically focused on those beneficiaries and providers that have not previously been in managed care. The final tour is being conducted after member selection materials are distributed, in November 2012, designed specifically to assist beneficiaries in fully understanding their options and selecting their KanCare plan.

In addition to beneficiary education, the providers that support HCBS waiver members have received additional outreach, information, transition planning and education regarding the KanCare program, to ensure an effective and smooth transition. In addition to the broader KanCare provider outreach (including educational tours and weekly stakeholder update calls), the providers that support HCBS waiver members have had focused discussions with state staff and MCO staff about operationalizing the KanCare program; about transition planning (and specific flexibility to support this) for the shift of targeted case management into MCO care management; and about member support in selecting their KanCare plan.

Beneficiaries received notices throughout November informing them of the changes that the KanCare program will bring effective 1.1.13, pending CMS approval; advising them as to which of the three KanCare plans they had been tentatively assigned to; explaining how to make a different choice if desired; describing the relative benefits available to them under each of the three KanCare plans; describing grievances and appeals; and providing contact information for eligibility and the enrollment broker,as well as each of the KanCare plans. A further notice will be mailed in late November-early December 2012 to HCBS beneficiaries specifically, which will specifically address the how the HCBS services will transition into KanCare, how the HCBS waiver services will continue, the 180 day transition safeguard for existing plans of care, and when applicable the role of new ADRC/level of care determination contractors. The materials provided are in languages, formats and reading levels to meet enrollee needs. The State will track returned mail and make additional outreach attempts for any beneficiary whose notification is returned.

During the first 180 days of the program, the State will continue with its educational activities after initial implementation to ensure providers, beneficiaries, and stakeholders are reminded of their enrollment and choice options.

2. Efforts to Preserve Existing Provider Relationships. Wherever possible, the State has pre-assigned members to a health plan in which its existing providers are participating. Beneficiaries will be allowed to access services with existing providers during the first 90 days of implementation, regardless of whether the provider is in the plan's network. If a new plan of care is not established in this 90 day period, this protection of both services and existing providers will continue up to either 180 days or the time a new plan of care is established. This period is extended to one year for residential service providers. For beneficiaries who do not receive a service assessment and revised service plan within the first 180 days, the health plan will be required to continue the service plan already in existence until a new service plan is created, agreed upon by the enrollee, and implemented. A member who does not receive a service assessment and revised service plan during the 90 day choice period may disenroll from his or her health plan "for cause" within 30 days of receiving a new plan of care, and select another KanCare plan managed care organization.

3. Information Sharing with KanCare Health Plans. Once the member is assigned to a health plan, the State and/or current case management entities will transmit the following data to the consumer's new MCO:
- Outstanding Prior Authorizations
- Functional assessments
- Plan of Care (along with associated providers)
- Notices of Action
- Historical claims
- Historical Prior Authorizations

This information serves as a baseline for the health plan's care management process and allows the care management team to assess the level of support and education the member may need.

4. Continuity of Services During the Transition. In order to maintain continuity of services and allow health plans time to outreach and assess the members, the State of Kansas has required the KanCare health plans to authorize and continue all existing PD services for a period of 180 days, or until a comprehensive needs assessment is completed face-to-face and a new, person centric plan of care, is developed and approved.

Also, to ensure continuity of services, the State will allow providers to continue to use the State's MMIS to enter claims. The option will ease a technical consideration of the transition for providers who do not have experience billing directly to commercial clearinghouses or other payers.

5. Intensive State Oversight. Kansas Department for Aging and Disability Services long term care licensure and quality assurance staff will provide oversight and "ride alongs" with health plan staff to ensure a smooth transition for the first 180 days. The State will review any reductions or termination of services and must approve any reduction in advance of the change.

Enrolees will have all appeal rights afforded through the MCO and state fair hearing process, including the ability to continue services during the appeal.

The State will require each health plan to maintain a call center and will review call center statistics daily. The State will also hold regular calls with each health plan to discuss key operational activities and address any concerns or questions that arise. Issues to be discussed can include, but are not limited to, network reporting and provider panel size reports, call center operations, reasons for member calls, complaint and appeal tracking, health plan outreach activities, service planning, data transfer, claims processing, and any other issue encountered during transition. The State will also review beneficiary complaints and grievances/appeals during the initial implementation on a frequent basis, and will have comprehensive managed care oversight, quality improvement and contract management.

6. Designation of an Ombudsman. There will be a KanCare Ombudsman in the Kansas Department for Aging and Disability Services. The KanCare Ombudsman helps people in Kansas who are enrolled in a KanCare plan, with a primary focus on individuals participating the HCBS waiver program or receiving other long term care services through KanCare.

The KanCare Ombudsman helps health plan members with access and service concerns, provides information about the KanCare grievance and appeal process that is available through the KanCare plans and the state fair hearing process, and assists KanCare consumers seek resolution to complaints or concerns regarding their fair treatment and interaction with their KanCare plan.

The KanCare Ombudsman will:
Help consumers to resolve service-related problems when resolution is not available directly through a provider or health plan.
Help consumers understand and resolve notices of action or non-coverage.
Assist consumers learn and navigate the grievance and appeal process at the KanCare plan, and the State fair hearing process, and help them as needed.
Assist consumers to seek remedies when they feel their rights have been violated.
Assist consumers understand their KanCare plan and how to interact with the programs benefits.

7.There is no impact to children and adults currently served on the waiver, as the State is not reducing the number of individuals served. Of the 13 youth currently on the PD wait list, four are enrolled in CHIP, and six in Medicaid. Three of the 13 do not currently have coverage. Therefore, as the State previously had indicated, we are reserving five waiver slots for individuals ages 16 to 19 applying for the waiver who may need to enroll to secure Medicaid eligibility. With this mechanism in place, there is no possibility that a child's access to Medicaid eligibility would be restricted or slowed as a result of the change in waiver slots

Attachment #2: Home and Community-Based Settings Waiver Transition Plan
Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.
Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.
To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301 (c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.
Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.
Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

1. Developed Transition Plan for HCBS settings for HCBS Final Setting Rule
a. KDADS has developed a statewide transition plan for bringing HCBS provider-owned and provider-controlled settings into compliance with new HCBS settings. We propose a 5 year allowance to carry the transition plan for the HCBS Programs. The plan is as follows:

The new Home and Community Based Services (HCBS) Settings Rule from the Centers for Medicare and Medicaid Services (CMS) applies to all programs that provide HCBS. In Kansas, this rule will apply to all settings where HCBS are provided

This Transition Plan ensures that all programs are in compliance with the new settings requirements and meets the expectations of CMS prior to submission of the Statewide HCBS Settings Compliance Transition Plan. The Final Transition Plan will include:

An Overall Summary of:

- Public comments received
- Inventory and description of all HCBS settings

• How setting types meet or does not meet the federal HCBS settings requirements

An Assessment Plan

• To Complete assessments for HCBS Settings
• To identify areas of non-compliance that need to be addressed
• To identify the number of individuals affected by the HCBS Settings Rule

A Compliance Plan

• To ensure the health and safety of participants who reside in locations that need to meet corrective action requirements for setting to come into compliance during the State's specified transition timeline
• To move individuals to compliant settings, if necessary
• In April, the KDADS, Medicaid operating agency, and KDHE, single State Medicaid agency, identified settings that should be reviewed for compliance with the HCBS Final Rule related to HCBS settings.

Over the first six months of the Transition Plan, KDADS will conduct provider assessments and develop a compliance summary from each provider type and identify areas of non-compliance for further review. This assessment will provide the basis for identifying, settings in compliance with the rule, settings requiring heightened scrutiny, and settings no longer qualifying for HCBS.

KDADS will assess all provider setting types to identify the scope of compliance and measure the impact on individual HCBS participants within 180 days of approval of the Transition Plan. The assessment will identify non-compliant settings and barriers to achieving compliance that require additional time to address. The assessment will also identify settings which are deemed ineligible by the new rule for which relocation of HCBS participants will be required. Kansas will use self-assessments, attestations, policy and record review, participant and provider interviews, observations, and other tools to determine compliance with respect to the new rule.

• Non-residential settings will be reassessed if additional guidance from CMS warrants more information to determine compliance with the new rule. Non-residential settings will be assessed pending CMS additional guidance and within 90 days of approval of the Transition Plan.
• Quality Management Specialists (QMS), Health Facility Surveyors, and MCO Care Coordinators will assist the State in identifying compliance related issues through normally occurring interactions, and targeted reviews when heightened scrutiny is determined appropriate or when settings are determined likely ineligible for HCBS. Additional protocols will be added to existing quality review materials as part of ongoing compliance and quality assurance.
• HCBS settings will be provided the results of the assessment. Non-compliant settings will be asked to participate in Focus Groups following the completion of statewide assessment period. The Focus Groups will identify areas and reasons of non-compliance and additional guidelines and benchmarks for compliance with the Final Rule to ensure compliance of all HCBS settings. HCBS settings will be required to submit a plan of correction to address any identified areas of non-compliance which will be reviewed and accepted or rejected by the state.

During the next 12 months, the State will review existing policies, regulations and statutes to identify barriers to compliance or conflicting information that hinders compliance. State law changes will be initiated to ensure compliance with HCBS Settings Rule and other elements of the CMS Final Rule, if appropriate.

Within 12 months of approval of the Transition Plan, the State will notify all HCBS settings and providers of their compliance with the new Final Rule. All settings that are currently in compliance will be identified and shared publically with MCOs, stakeholders and consumers. HCBS settings that need additional time to come into compliance will be notified of non-compliance areas, timelines for compliance, and benchmarks to achieving compliance within the shortest timeframe possible.

• HCBS participants over sixty-five (65) who currently reside in a setting that is no longer determined eligible to provide HCBS services under the New Rule will be grandfathered in their current setting as HCBS eligible during the five (5) years after the approval of the Transition Plan if their individual conditions indicate move from the current setting would reasonably pose a risk to their physical or psychological well-being, or prohibited from accepting new HCBS participants unless compliance with the new rule can be achieved.
• Settings that have regulatory or statutory limitations will be notified of the process, plan and timeline to complete changes to regulation and state law to comply with the new Final Rule. This process may take up to two (2) years to complete. Compliance steps will be required for the parts of the Final Rule that are not affected by regulatory or statutory limitations. Individuals and providers will be notified of the process, plan and timeline for all settings to come into compliance.
• The State will update all provider manuals, consumer handbooks, and guides to incorporate the Final Rule requirements

within 90 days of completion of the Assessment and Compliance Review activities. Ongoing updates will be made as settings become compliant with the new rule or regulation and statutes changed. Non-compliant settings will be monitored by the quality assurance and program integrity group during the transition plan. Failure to comply by the established deadlines could result in a final determination that the setting is non-compliant, and the transition plan for individuals will be implemented.

For settings that are not compliant with the new Final Rule, the State will ensure appropriate transitions by working with stakeholders and community partners. Additional stakeholder input will be required to develop a comprehensive plan for transition. However, all HCBS participants will be afforded education and information about their rights and responsibilities prior to a transition from a non-compliant setting to a compliant setting. The State will establish a transition policy for relocation or transition to compliant settings after public input and comment that will address the process for transition, ensure choice is provided, and identify timeframes for appropriate transition.

Over the next five years, the Kansas Department for Aging and Disability Services (KDADS) will ensure that all residential and non-residential locations where a person receives home and
Community-based services (HCBS) through Medicaid allows individuals to be integrated in and have support for full access to services in the greater community, including opportunities to seek
Employment and work in competitive integrated settings, to control personal resources, and to engage in community life in the same way as individuals not receiving Medicaid HCBS.

In HCBS settings, the individual will have:
- A lease or a written agreement with eviction and appeals rights
- Choice of settings and roommates based on their needs, preferences, and resources
- Choice of services and supports, and who provides
- Rights of privacy (lockable doors), dignity, respect, and freedom from coercion and restraint
- Right to control personal resources and make money in a job in the community
- Support for choice of daily activities, physical environment, and with whom to interact
- Freedom and support to control their own schedules, activities, and access food at any time
- Right and ability to have visitors of their choosing at any time
- A setting that is physically accessible, including ADA compliant
- Any limit or restriction supported by a specific assessed need, evaluated frequently, and be approved by the individual, parent or guardian

All provider controlled and owned residential and non-residential settings will be reviewed (regardless of license requirements), within 180 days of approval of the Transition Plan to identify settings that do not meet the rule and need additional time to address. KDADS does not anticipate HCBS setting compliance issues due to the program recipients being primarily children who are served in their family homes, or similar settings, and the identified limitations in residential settings will not apply to their services and supports. The settings will be evaluated for compliance regarding non-residential settings when federal guidance is available. Noncompliance will be addressed on a case-by-case basis.

During 2015, KDADS will assess all HCBS Settings by June 30, 2015 to identify settings that comply with the HCBS Setting Rule and review state law and program policies that may need to be changed. KDADS will make changes to the Transition Plan in 2015 to set more specific timelines and benchmarks for compliance. By December 31, 2015, KDADS will identify all providers and individuals who may be affected by the changing rules and seek public input on timeframes and benchmarks. During 2016, KDADS will notify all HCBS providers of non-compliance areas, timelines for compliance and benchmarks for achieving compliance in the shortest period possible. KDADS may change the Transition Plan to ensure compliance with the HCBS Setting Rules based on the State's Transition Plan for Access, Compliance and Public Engagement

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

N/A

Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

○ **The waiver is operated by the State Medicaid agency.**

Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

○ **The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

○ **Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.**

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

(Complete item A-2-a).

◉ **The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.**

Specify the division/unit name:
Kansas Department for Aging and Disability Services/Community Services and Programs Commission

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
Kansas Department of Health and Environment (KDHE), which is the single state Medicaid agency (SSMA), and the Kansas Department for Aging and Disability Services (KDADS) have an interagency agreement which, among other things:
• Specifies that the SSMA is the final authority on compensatory Medicaid costs.
• Recognizes the responsibilities imposed upon the SSMA as the agency authorized to administer the Medicaid program, and the importance of ensuring that the SSMA retains final authority necessary to discharge those responsibilities.
• Requires the SSMA approve all new contracts, MOUs, grants or other similar documents that involve the use of Medicaid funds.

• Notes that the agencies will work in collaboration for the effective and efficient operation of Medicaid health care programs, including the development and implementation of all program policies, and for the purpose of compliance with all required reporting and auditing of Medicaid programs.
• Requires the SSMA to provide KDADS with professional assistance and information, and both agencies to have designated liaisons to coordinate and collaborate through the policy implementation process.
• Delegates to KDADS the authority for administering and managing certain Medicaid-funded programs, including those covered by this waiver application.
• Specifies that the SSMA has final approval of regulations, SPAs and MMIS policies, is responsible for the policy process, and is responsible for the submission of applications/amendments to CMS in order to secure and maintain existing and proposed waivers, with KDADS furnishing information, recommendations and participation. (The submission of this waiver application is an operational example of this relationship. Core concepts were developed through collaboration among program and operations staff from both the SSMA and KDADS; functional pieces of the waiver were developed collectively by KDHE and KDADS staff; and overview/approval of the submission was provided by the SSMA, after review by key administrative and operations staff and approval of both agencies' leadership.)
In addition to leadership-level meetings to address guiding policy and system management issues (both ongoing periodic meetings and as needed, issue-specific discussions), the SSMA ensures that KDADS performs assigned operational and administrative functions by the following means:

a. Regular meetings are held by the SSMA with representatives from KDADS to discuss:
• Information received from CMS;
• Proposed policy changes;
• Waiver amendments and changes;
• Data collected through the quality review process
• Eligibility, numbers of consumers being served
• Fiscal projections; and
• Any other topics related to the waivers and Medicaid.
b. All policy changes related to the waivers are approved by KDHE. This process includes a face to face meeting with KDHE staff.
c. Waiver renewals, 372 reports, any other federal reporting requirements, and requests for waiver amendments must be approved by KDHE.
d. Correspondence with CMS is copied to KDHE.

Kansas Department of Health and Environment, as the single state Medicaid agency, has oversight responsibilities for all Medicaid programs, including direct involvement or review of all functions related to HCBS waivers. In addition, under the KanCare program, as the HCBS waiver programs merge into comprehensive managed care, KDHE will have oversight of all portions of the program and the KanCare MCO contracts, and will collaborate with KDADS regarding HCBS program management, including those items identified in part (a) above. The key component of that collaboration will be through the KanCare Interagency Monitoring Team, an important part of the overall state's KanCare Quality Improvement Strategy, which will provide quality review and monitoring of all aspects of the KanCare program – engaging program management, contract management, and financial management staff from both KDHE and KDADS.

The services in this waiver are becoming part of the state's KanCare comprehensive Medicaid managed care program. The quality monitoring and oversight for that program, and the interagency monitoring (including the SSMA's monitoring of delegated functions to the Operating Agency) will be guided by the KanCare Quality Improvement Strategy. A critical component of that strategy is the engagement of the KanCare Interagency Monitoring Team, which will bring together leadership, program management, contract management, fiscal management and other staff/resources to collectively monitor the extensive reporting, review results and other quality information and data related to the KanCare program and services. Because of the managed care structure, and the integrated focus of service delivery/care management, the core monitoring processes – including IMT meetings – will be on a quarterly basis. While continuous monitoring will be conducted, including on monthly and other intervals, the aggregation, analysis and trending processes will be built around that quarterly structure. Kansas will be amending the KanCare QIS to include the concurrent HCBS waiver connections, and once the QIS is operational (and within 12 months of KanCare launching) will be seeking CMS approval of amendments of the HCBS waivers that embed the KanCare QIS structure.

Appendix A: Waiver Administration and Operation

3. **Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*
The state's contracted Aging & Disability Resource Center (ADRC) conducts participant waiver assessment and level of care evaluation activities for current and potential consumers, as well as options counseling.

Managed Care Organizations conduct plan of care development and related service authorization, develop and review service plans, assist with utilization management, conduct provider credentialing, provider manual, and other provider guidance; and participate in the comprehensive state quality improvement strategy for the KanCare program including this waiver.

○ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. **Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

◉ **Not applicable**

○ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.
Check each that applies:

☐ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

☐ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:
Kansas Department for Aging and Disability Services/ Community Services and Programs Commission

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative

functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:
Contracted entities, including both contracted entities/providers and the state's contracted KanCare managed care organizations, are monitored through the State's KanCare Quality Improvement Strategy, which will provide quality review and monitoring of all aspects of the KanCare program – engaging program management, contract management, and financial management staff from both KDHE and KDADS. All functions delegated to contracted entities will be included in the State's comprehensive quality strategy review processes. A key component of that monitoring and review process will be the KanCare Interagency Monitoring Team, which will include HCBS waiver management staff from KDADS. In addition, the SSMA and the State operating agency will continue to operate collaboratively under an interagency agreement, as addressed in part A.2.b above, and that agreement will including oversight and monitoring of all HCBS programs and the KanCare MCOs and independent assessment contractors.

The KanCare Quality Improvement Strategy and interagency agreements/monitoring teams will ensure that the entities contracting with KDADS (the Waiver Operating Agency) are operating within the established parameters. These parameters include CMS rules/guidelines, the approved KanCare managed care contracts and related 1115 waiver, Kansas statutes and regulations, and related policies. Included in the QIS will be ongoing assessment of the results of onsite monitoring and in-person reviews with a sample of HCBS waiver participants. The KanCare Interagency Monitoring Team (IMT) will meet quarterly, and during the initial year of the KanCare program will have additional meetings of members involved in HCBS quality activities at both the single state Medicaid agency (KDHE) and the operating agency (KDADS). During the first 12 months of KanCare, as noted in the 1115 STC #45, the state will have flexibility in merging existing quality monitoring practices and protocols into the Comprehensive State Quality Strategy addressed in STC #37, and reporting the results of the strategy in connection of the HCBS waiver service oversight and monitoring. Once that review and merger process is completed, and related HBCS waiver amendments are submitted (by 12.13.13), the comprehensive KanCare SQS will be revised within 90 days of approval of the HCBS waiver amendments submitted. Included in the revised SQS will be a description of monitoring/assessment of the contracted entities, including the IMT's quarterly review of the results that monitoring/assessment.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency.
Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
Participant waiver enrollment	☑	☑	☑
Waiver enrollment managed against approved limits	☑	☑	☑
Waiver expenditures managed against approved levels	☑	☑	☐
Level of care evaluation	☑	☑	☑
Review of Participant service plans	☑	☑	☑
Prior authorization of waiver services	☑	☑	☑
Utilization management	☑	☑	☑
Qualified provider enrollment	☑	☑	☑
Execution of Medicaid provider agreements	☑	☐	☐
Establishment of a statewide rate methodology	☑	☑	☐
Rules, policies, procedures and information development governing the waiver program	☑	☑	☑
Quality assurance and quality improvement activities	☑	☑	☑

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Administrative Authority**
The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. **Performance Measures**

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. *As necessary and applicable, performance measures should focus on:*

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of waiver policy changes that were submitted to the State Medicaid Agency prior to implementation by the Operating Agency N=Number of waiver policy changes that were submitted to the State Medicaid Agency prior to implementation by the Operating Agency D=Number of waiver policy changes implemented by the Operating Agency

Data Source (Select one):
Other
If 'Other' is selected, specify:
Presentation of waiver policy changes

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ Other Specify:	☐ Annually	☐ Stratified Describe Group:
	☑ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☑ State Medicaid Agency	☐ Weekly
☑ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☐ Other Specify:	☑ Annually
	☑ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:
Number and percent of Long-Term Care meetings that were represented by the program managers through in-person attendance or written reports N=Number of Long-Term Care meetings that were represented by the program managers through in-person attendance or written reports D=Number of Long-Term Care meetings

Data Source (Select one):
Meeting minutes
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach*(check each that applies):*
☑ State Medicaid Agency	☐ Weekly	☑ 100% Review
☑ Operating Agency	☐ Monthly	☐ Less than 100% Review

☐ Sub-State Entity	☐ Quarterly	☐ Representative Sample Confidence Interval =
☐ Other Specify:	☐ Annually	☐ Stratified Describe Group:
	☑ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☑ State Medicaid Agency	☐ Weekly
☑ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☐ Other Specify:	☑ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:
Number and percent of Quality Review reports generated by KDADS, the Operating Agency, that were submitted to the State Medicaid Agency N=Number of Quality Review reports generated by KDADS, the Operating Agency, that were submitted to the State Medicaid Agency D=Number of Quality Review reports

Data Source (Select one):
Other
If 'Other' is selected, specify:
Quality Review reports

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach*(check each that applies):*
☐ State Medicaid Agency	☐ Weekly	☑ 100% Review
☑ Operating Agency	☐ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☑ Quarterly	☐ Representative Sample Confidence Interval =
☐ Other Specify:	☐ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☑ State Medicaid Agency	☐ Weekly
☑ Operating Agency	☐ Monthly
☐ Sub-State Entity	☑ Quarterly
☐ Other Specify:	☐ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:

Number and percent of waiver amendments and renewals reviewed and approved by the State Medicaid Agency prior to submission to CMS by the State Medicaid Agency N=Number of waiver amendments and renewals reviewed and approved by the State Medicaid Agency prior to submission to CMS D=Total number of waiver amendments and renewals

Data Source (Select one):
Other
If 'Other' is selected, specify:
Waiver amendments and renewals

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
	☑ Continuously and Ongoing
	☐ Other Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
Kansas Department of Health and Environment, Division of Health Care Finance (KDHE), the single state Medicaid agency, and Kansas Department for Aging and Disability Services (KDADS) work together to develop state operating agency priority identification regarding all waiver assurances and minimum standards/basic assurances. The state agencies work in partnership with consumers, advocacy organizations, provider groups and other interested stakeholders to monitor the state quality strategy and performance standards and discuss priorities for remediation and improvement. The state quality improvement strategy includes protocols to review cross-service system data to identify trends and opportunities for improvement related to all Kansas waivers, policy and procedure development and systems change initiatives.

Data gathered by KDADS Regional Staff during the Quality Survey Process is compiled quarterly for evaluation and trending to identify areas for improvement. Upon completion of identified areas of improvement this information is compiled into reports and shared both internally and externally, including with KDHE. As the KanCare program is operationalized, staff of the three plans will be engaged with state staff to ensure strong understanding of Kansas' waiver programs and the quality measures associated with each waiver program. These measures and collection/reporting protocols, together with others that are part of the KanCare MCO contract, are included in a statewide comprehensive KanCare quality improvement strategy which is regularly reviewed and adjusted. That plan is contributed to and monitored through a state interagency monitoring team, which includes program managers, fiscal staff and other relevant staff/resources from both the state Medicaid agency and the state operating agency.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
State staff and/or KanCare MCO staff request, approve, and assure implementation of provider corrective action planning and/or technical assistance to address non-compliance with waiver and performance standards as detected through on-site monitoring, survey results and other performance monitoring. These processes are monitored by both program managers and other relevant state and MCO staff, depending upon the type of issue involved, and results tracked consistent with the statewide quality improvement strategy and the operating protocols of the Interagency Monitoring Team.
Monitoring and survey results are compiled, trended, reviewed, and disseminated consistent with protocols identified in the statewide quality improvement strategy. Each provider receives annual data trending which identifies Provider specific performance levels related to statewide performance standards and statewide averages. Corrective Action Plan requests, technical assistance and/or follow-up to remediate negative trending are included in annual reports where negative trending is evidenced.

ii. **Remediation Data Aggregation**

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☑ State Medicaid Agency	☐ Weekly
☑ Operating Agency	☐ Monthly
☐ Sub-State Entity	☑ Quarterly

Responsible Party(*check each that applies*):	Frequency of data aggregation and analysis(*check each that applies*):
☐ Other Specify:	☑ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

c. **Timelines**
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

◉ **No**

○ **Yes**
Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. **Target Group(s).** Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☑ Aged or Disabled, or Both - General					
	☐	Aged			☐
	☑	Disabled (Physical)	16	64	
	☐	Disabled (Other)			
☐ Aged or Disabled, or Both - Specific Recognized Subgroups					
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
☐ Intellectual Disability or Developmental Disability, or Both					
	☐	Autism			☐
	☐	Developmental Disability			☐
	☐	Intellectual Disability			☐
☐ Mental Illness					

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	☐	Mental Illness			
	☐	Serious Emotional Disturbance			

b. **Additional Criteria.** The State further specifies its target group(s) as follows:

Consumers must meet the level of care required for Nursing Facility placement determined by the Medicaid Long Term Care (LTC) threshold score for Physical Disability (PD) based on an assessment using the functional assessment instrument in order to be eligible for PD waiver services. Eligibility is assessed annually using the functional assessment instrument. Consumers must also be determined physically disabled by Social Security standards. Individual with [SPMI] diagnosis must also be determined physically disabled by Social Security standard.

The criteria excludes those persons who have only a diagnosis of severe and persistent mental illness [SPMI], and severe emotional disturbance (SED), and must not meet the definition of having intellectual or developmental disability (I/DD) as established by Kansas Statute 39-1803.

If under age 21years, a PD waiver consumer must have a KAN-Be-Healthy (EPSDT) screening completed on an annual basis.

Contractors will conduct eligibility determination in accordance with the CMS approved level of care criteria. The program eligibility criteria requires consumers meet the level of care required for Nursing Facility placement determined by the Medicaid Long Term Care (LTC) threshold score for Physical Disability (PD) based on an assessment using the functional assessment instrument in order to be eligible for PD waiver services. Eligibility is assessed annually using the state approved functional assessment instrument in accordance with the established criteria.

The criteria for PD waiver level of care eligibility are as follows:
1. Be between the ages of 16 and 64.
2. Consumer must be a Kansas resident
3. Be determined physically disabled by the Social Security Standard as defined below. In the event the disability determination does not clearly indicate a "physical disability", the State will request additional documentation to support the individual's disability. The documentation provided must have relevant information to support the person's physical disability.
4. Need assistance to perform activities of daily living.
5. Meet the level of care required for Nursing Facility placement determined by the Medicaid Long Term Care (LTC) threshold score for Physical Disability (PD) based on the functional assessment instrument.
6. If under age 21 years, the individual must have a current KAN-Be-Healthy (EPSDT) screening.

c. **Transition of Individuals Affected by Maximum Age Limitation.** When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

○ **Not applicable. There is no maximum age limit**

◉ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

PD eligible individuals 65 years of age or older receiving services prior to 1/1/15 have the option to continue receiving services under the PD program or transition to the FE program, provided they meet established criteria.

Effective 1/1/15, consumers served on the PD waiver who are approaching the age of 65 years must transition to the HCBS Frail Elderly (FE) waiver, provided they meet established criteria.

PD consumers who have participated in the WORK program have the option to return to the PD program and bypass the waitlist. Consistent with CMS required annual eligibility redetermination, the consumer must be

reassessed for PD level of care eligibility within 90 days of leaving the WORK program. If the consumer is determined to not meet level of care eligibility, KDADS will terminate services using established process, including appeal rights.

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. **Individual Cost Limit.** The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*. Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

◉ **No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

○ **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

The limit specified by the State is *(select one)*

○ **A level higher than 100% of the institutional average.**

Specify the percentage:

○ **Other**

Specify:

○ **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*

○ **Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

The cost limit specified by the State is *(select one)*:

○ **The following dollar amount:**

Specify dollar amount:

The dollar amount *(select one)*

○ **Is adjusted each year that the waiver is in effect by applying the following formula:**

Specify the formula:

May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.

The following percentage that is less than 100% of the institutional average:

Specify percent:

Other:

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

b. **Method of Implementation of the Individual Cost Limit.** When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

c. **Participant Safeguards.** When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

☐ **The participant is referred to another waiver that can accommodate the individual's needs.**

☐ **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. **Unduplicated Number of Participants.** The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	7092
Year 2	

Waiver Year	Unduplicated Number of Participants
	7092
Year 3	7092
Year 4	7092
Year 5	7092

b. **Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

○ **The State does not limit the number of participants that it serves at any point in time during a waiver year.**

◉ **The State limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	6092
Year 2	6092
Year 3	6092
Year 4	6092
Year 5	6092

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. **Reserved Waiver Capacity.** The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

○ **Not applicable. The state does not reserve capacity.**

◉ **The State reserves capacity for the following purpose(s).**

Purpose(s) the State reserves capacity for:

Purposes	
WORK Program	
Temporary Insitutonal Stay	
Money Follows the Person (MFP)	
Military Inclusion	
PD Eligible Participants 16-19 years	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

WORK Program

Purpose *(describe):*

The State reserves capacity for HCBS TBI program participants who have participated in the WORK program have the option to return to the program and bypass the waitlist if the program maintains a waitlist. Consistent with CMS required annual eligibility redetermination; participants must be reassessed within 90 days of leaving the WORK program in accordance with program eligibility level of care requirements. If the consumer is determined to not meet level of care eligibility, KDADS will terminate services using established process, including appeal rights

Describe how the amount of reserved capacity was determined:

The amount of reserved capacity is determined using actual number of past participants who transition back to the PD waiver from the WORK program.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	5
Year 2	5
Year 3	5
Year 4 (renewal only)	5
Year 5 (renewal only)	5

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Temporary Insitutonal Stay

Purpose *(describe):*

The state reserves capacity to maintain continued waiver eligibility for participants who enters into an institution such as hospitals, ICF/ID or nursing facilities for the purpose of seeking treatment for acute, habilitative or rehabilitative conditions on a temporary basis less than 90 days. Temporary stay is defined as a stay that includes the month of admission and two months following admission. Consumers that remain in the institution following the two month allotment will be terminated from the HCBS program. The consumer can choose to reapply for services at a later date and will be reinstated if the consumer meets program eligibility requirements or placed on a waiting list if applicable.

Describe how the amount of reserved capacity was determined:

This amount is projected reserved capacity.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	150
Year 2	150
Year 3	150
Year 4 (renewal only)	150
Year 5 (renewal only)	150

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Money Follows the Person (MFP)

Purpose *(describe):*

The State reserves capacity for individuals transitioning from the MFP grant program to the HCBS-PD waiver. These individuals are moved onto the waiver immediately following the expiration of their MFP grant benefits.

In addition: State waiver appropriations historically have determined the number of individuals that can be served in the waiver. Funding for slots will continue to be appropriated separately for each waiver. To the extent annual appropriations remain constant or increase as savings from KanCare are realized, the State intends to increase the number of individuals served and reserves the ability to amend the waiver accordingly.

Describe how the amount of reserved capacity was determined:

MFP reserve capacity is based upon historial experience as to people who have chosen to enter the MFP program and anticipated related transitions.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	
Year 2	
Year 3	110
Year 4 (renewal only)	110
Year 5 (renewal only)	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Military Inclusion

Purpose *(describe):*

The State reserves capacity for military participants and their immediate dependent family members who have been determined program eligible may bypass waitlist upon approval by KDADS.

Individuals who have been determined to meet the established PD waiver criteria will be allowed to bypass the waitlist and access services.

Describe how the amount of reserved capacity was determined:

There are no data to support this projection of reserved capacity. If the amount of need exceeds reserve capacity,Kansas will submit an amendment to appropriately reflect the number unduplicated persons served.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	5
Year 2	5
Year 3	5
Year 4 (renewal only)	5
Year 5 (renewal only)	5

Appendix B: Participant Access and Eligibility
B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

PD Eligible Participants 16-19 years

Purpose *(describe):*

The State reserves capacity for PD waiver partipants age 16-19 years who may eligible to enter to the program during waiver year 5 of this amendment, may bypass the waitlist if the individual meet the criteria established by KDADS.

Describe how the amount of reserved capacity was determined:

The number of reserved capacity is based on actual PD waitlist data.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	
Year 2	
Year 3	
Year 4 (renewal only)	
Year 5 (renewal only)	5

Appendix B: Participant Access and Eligibility
B-3: Number of Individuals Served (3 of 4)

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

◎ **The waiver is not subject to a phase-in or a phase-out schedule.**

○ **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

◉ **Waiver capacity is allocated/managed on a statewide basis.**

○ **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

To be eligible for HCBS-PD waiver services, consumers must (a) be between the minimum age of 16 years and the maximum age of 64 years; (b) meet the Medicaid long term care threshold; (c) be disabled according to Social Security Disability Standards; and (d) be determined functionally eligible for PD waiver services according to the PD Uniform Assessment Instrument and threshold guide level of care score (K.A.R. 30-5-305; K.A.R. 30-5-309). In the event the disability determination does not clearly indicate a "physical disability", the State will request additional documentation to support the individual's disability. The documentation provided must have relevant information to support the person's physical disability.

Entry into the waiver is based on a first-come, first-served basis for applicants determined eligible. In the event there is a waiting list, entry is based on the time and date the assessment is completed. Responsibility for managing the witing list remains with the State (KDHE and KDADS).
1. Consumers may supersede the waiting list if they meet any one of the following groups:
2. Consumers transferring directly from another HCBS waiver;
3. Consumers transferring directly from the WORK program;
4. Applicants identified and approved as a Crisis Exceptions to the waiting list as established by Kansas Department for Aging and Disability Services/ Community Services and Program Commission (KDADS);
5. Consumers exiting a Medicaid approved nursing facility through the Money Follows the Person program, who previously gained access in this manner, will now gain access under reserve capacity;
6. Military participants and their immediate dependent family members (as defined by IRS) who have been determined program eligible may bypass waitlist upon approval by KDADS if the individual meets the following criteria:
a. A resident of Kansas or has maintained residency in Kansas as evidence by tax return or other documentation demonstrating proof of residency
b. Must be active or recently separated (within 30 days) military personnel or dependent family members who are eligible to receive TriCare Echo
c. Have been receiving Tricare Echo at the time of separation from the military
d. Received an honorable discharge as indicated on the DD form 214
For the purpose of the military inclusion, IRS defines immediate family as a spouse, child, parent, brother or sister of the individual in the military (IRS 1.25.1.2.2).
All individuals are held to the same criteria when qualifying for a crisis exception as in accordance with statewide policies and guidelines.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a *(select one)*:
   - ○ §1634 State
   - ◉ SSI Criteria State
   - ○ 209(b) State

2. **Miller Trust State.**
   Indicate whether the State is a Miller Trust State *(select one)*:
   - ◉ No
   - ○ Yes

b. **Medicaid Eligibility Groups Served in the Waiver.** Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- ☑ Low income families with children as provided in §1931 of the Act
- ☑ SSI recipients
- ☐ Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121
- ☐ Optional State supplement recipients
- ☐ Optional categorically needy aged and/or disabled individuals who have income at:

  Select one:

  - ○ 100% of the Federal poverty level (FPL)
  - ○ % of FPL, which is lower than 100% of FPL.

  Specify percentage:

- ☐ Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)
- ☐ Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)
- ☐ Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)
- ☐ Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)
- ☐ Medically needy in 209(b) States (42 CFR §435.330)
- ☑ Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)
- ☐ Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)

  Specify:

Special home and community-based waiver group under 42 CFR §435.217) Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed

- ○ **No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*

◉ **Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

○ **All individuals in the special home and community-based waiver group under 42 CFR §435.217**

◉ **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

Check each that applies:

☑ **A special income level equal to:**

Select one:

◉ **300% of the SSI Federal Benefit Rate (FBR)**

○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

○ **A dollar amount which is lower than 300%.**

Specify dollar amount:

☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**

☑ **Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**

☐ **Medically needy without spend down in 209(b) States (42 CFR §435.330)**

☐ **Aged and disabled individuals who have income at:**

Select one:

○ **100% of FPL**

○ **% of FPL, which is lower than 100%.**

Specify percentage amount:

☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 4)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

a. **Use of Spousal Impoverishment Rules.** Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217 *(select one):*

◉ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the State elects to (*select one*):

◉ **Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)

○ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

○ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 4)

b. Regular Post-Eligibility Treatment of Income: SSI State.

The State uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

○ **The following standard included under the State plan**

Select one:

○ **SSI standard**
○ **Optional State supplement standard**
○ **Medically needy income standard**
○ **The special income level for institutionalized persons**

(*select one*):

○ **300% of the SSI Federal Benefit Rate (FBR)**
○ **A percentage of the FBR, which is less than 300%**

Specify the percentage:

○ **A dollar amount which is less than 300%.**

Specify dollar amount:

○ **A percentage of the Federal poverty level**

Specify percentage:

○ **Other standard included under the State Plan**

Specify:

○ **The following dollar amount**

Specify dollar amount: If this amount changes, this item will be revised.

○ **The following formula is used to determine the needs allowance:**

Specify:

◎ **Other**

Specify:

Operationally, the State will continue to calculate patient liability, or member Share of Cost, and providers will continue to be responsible for collecting it. In practice, this means the State will reduce capitation payments by the individual Share of Cost amounts. The reduction will be passed from the MCO to the provider in the form of reduced reimbursement, and the provider will be responsible for collecting the difference.

The dollar amount for the allowance is $727. Excess income will only be applied to the cost of 1915(c) waiver services.

ii. Allowance for the spouse only (*select one*):

◎ **Not Applicable**

○ **The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**

Specify:

Specify the amount of the allowance (*select one*):

○ **SSI standard**

○ **Optional State supplement standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

Specify dollar amount: _____ If this amount changes, this item will be revised.

○ **The amount is determined using the following formula:**

Specify:

iii. Allowance for the family (*select one*):

○ **Not Applicable (see instructions)**

○ **AFDC need standard**

◎ **Medically needy income standard**

○ **The following dollar amount:**

Specify dollar amount: _____ The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

○ **The amount is determined using the following formula:**

Specify:

Other

Specify:

iv. **Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:**

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

Not Applicable (see instructions)*Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*

The State does not establish reasonable limits.

The State establishes the following reasonable limits

Specify:

Appendix B: Participant Access and Eligibility
B-5: Post-Eligibility Treatment of Income (3 of 4)

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility
B-5: Post-Eligibility Treatment of Income (4 of 4)

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. **Allowance for the personal needs of the waiver participant**

(*select one*):

SSI standard

Optional State supplement standard

Medically needy income standard

The special income level for institutionalized persons

○ **A percentage of the Federal poverty level**

Specify percentage:

◉ **The following dollar amount:**

Specify dollar amount: 727 If this amount changes, this item will be revised

○ **The following formula is used to determine the needs allowance:**

Specify formula:

○ **Other**

Specify:

ii. **If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.**

Select one:

◉ **Allowance is the same**

○ **Allowance is different.**

Explanation of difference:

iii. **Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:**

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

○ **Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*

◉ **The State does not establish reasonable limits.**

○ **The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. **Reasonable Indication of Need for Services.** In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

i. **Minimum number of services.**

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

ii. **Frequency of services.** The State requires (select one):

◉ **The provision of waiver services at least monthly**

○ **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. **Responsibility for Performing Evaluations and Reevaluations.** Level of care evaluations and reevaluations are performed (*select one*):

○ **Directly by the Medicaid agency**

○ **By the operating agency specified in Appendix A**

◉ **By an entity under contract with the Medicaid agency.**

Specify the entity:

State contracted assessors "Aging and Disablity Resource Center (ADRC)" contracting with Kansas is responsible for performing the evaluation and reevaluation for level of care determination.

○ **Other**
Specify:

c. **Qualifications of Individuals Performing Initial Evaluation:** Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Qualifications of ADRC Level of Care assessors:

Four year degree from an accredited college or university with a major in gerontology, nursing, health, social work, counseling, human development, family studies, or related area as defined by the ADRC; or a Registered Nurse license to practice in the state of Kansas.

The ADRC must verify experience, education and certification requirements are met for assessors identified in 2.7.3.A2-4. The ADRC must maintain these records for five (5) years following termination of employment.

Successfully complete the Functional Assessment Instrument (FEI) and Kansas Aging Management Information System (KAMIS) training prior to performing assessments.

Assessors and interviewers must attend initial certification and recertification training sessions that cover the forms (s) the assessor or interviewer is being certified to complete.

An assessor or interviewer that has not conducted any assessments or interviews within the last six months must repeat the training and certification requirements for the PD waiver functional assessment instrument.
KDADS shall have the responsibility for conducting all training sessions, certification and recertification of all FAI Assessors. KDADS shall provide training materials and written documentation of successful completion of training.

Assessors must participate in all state-mandated trainings to ensure proficiency of the program, services, rules,

regulations, policies and procedures set forth by KDADS.

Assessors must complete 15 hours of training or continuing education annually, with an emphasis in aging and disability topics, including, but not limited to: Annual training on the Independent Living Philosophy consisting of standardized training in history and philosophy of the National Independent Living Movement.

Tracking of staff training is a responsibility of the ADRC and should be recorded in the assessors personnel file.

d. **Level of Care Criteria.** Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

As established by state policy, consumers with physical disability must meet the level of care required for Nursing Facility placement, determined by the Medicaid Long Term Care (LTC) Threshold score for PD utilizing the functional eligiblity instrument (FEI). The FEI is a functional assessment of a consumer's Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs).

Currently, PD eligibile individuals must meet the level of care required for nursing facility placement as determined by the Medicaid Long Term Care (LTC) threshold score using a Functional Eligibilitiy Instrument. The Functional Eligibility Instrument is an assessment of an individual's capacity for Activities of Daily Living (ADLs)and Instrumental Activities of Daily Living(IADLs). The functional eligibility instrument measures an individual's behavioral/emotional deficits and cognitive limitations that will be critical to the development of a participant's Plan of Care (POC).

Alternatively, Kansas has contracted with Kansas University (KU) to evaluate the current assessment instrument in comparison to other States to identify an assessment instrument with demonstrated reliability and validity. The purpose of this contract is to develop a standardized eligibility assessment to assess level of care eligibility for all HCBS populations served by Kansas programs. This study seeks input from assessors, stakeholders and entities who work with HCBS populations as subject matter experts, in order to provide input on assessment instruments recommended for consideration. The contractor has concluded their study and has submitted recommendations to Kansas for review and approval.

A draft of the standardized eligibility instrument has been developed based upon input collected the assessors, stakeholders, and entities who work with the HCBS populations. The standardized eligibility instrument draft will be tested and administered with the current functional eligibility instrument during a four to six month time period. Following the conclusion of the testing, the standardized eligibility instrument will be refined and adjusted based on data collected during the field testing until a final version of the eligibility instrument is developed. Input from assessor, stakeholder, and entities who work with HCBS populations will continued to be gathered throughout the process and planning webinars about the eligibility instrument will be provided for additional providers and the public. Once the eligibility instrument has been finalized, an in-depth training on the instrument will be provided to assessors.

Following final decision of a statewide eligibility assessment instrument, Kansas will develop a work plan to implement a phase in assessment process to include dual assessment using the current assessment tool and the new statewide assessment instrument in order to evaluate outcome. Kansas anticipates a phase-in implementation of the new statewide assessment instrument to begin by 01/1/15. In order to comply with CMS requirement, Kansas will be submitting an amendment for all HCBS programs to include the new statewide assessment instrument for CMS review and approval 90 days prior to planned implementation date.

e. **Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

◉ **The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**

○ **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

f. **Process for Level of Care Evaluation/Reevaluation:** Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

The level of care criteria utilized for initial assessments of HCBS PD waiver applicants and yearly reassessments of waiver services consumers is the level of care criteria utilized by Nursing Facilities. The contracted assessors will screen for reasonable indicator of meeting the level of care eligibility prior to administering the functional eligibility instrument. Applicants and current consumers must meet the Medicaid Long Term Care Threshold score based on an assessment completed with the functional eligibility instrument (FEI). The level of care assessment and reassessment process is conducted by a qualified assessors contracted with Kansas. Information used to determine scores and other eligibility criteria can come from a variety of sources. The consumer is the primary source of information. The ADRC uses interview techniques that are considerate of any limitations the consumer might have with hearing, eyesight, cognition, etc. Family members and other individuals who might have relevant information about the consumer can also be interviewed. The contracted assessors may also use clinical records, if available, and/or discuss the consumer's status with the appropriate medical professional.

All community referrals may contact the ADRC directly, the ADRC will intake pertinent referral information and conduct preliminary screening for reasonable indicators of meeting the program level of care criteria. Required documentations for determining reasonable indicator for level of care eligibility are as follows: Documentation of Social Security determination; and documentations with relevant information to support the person's physical disability. Applicant may utilize the KDADS template as documentation of relevant information signed by attending healthcare professional. Once the ADRC intake staff completes the above step, they will forward the referral to the ADRC assessor. The assessor will conduct functional eligibility determination using the State approved functional eligibility instrument. The assessor will submit the completed assessment and supporting documentations to the KDADS system of record. If additional documentation is needed, KDADS will request additional documentation from ADRC or applicant as necessary. KDADS program manager will review the submitted documentation for program eligibility and communicate eligibility determination to applicant and DCF.

If the applicant is applying for the PD waiver or Money Follows the Person Program and has met the required stay of 90 days in an ICF-MR or nursing facility. Applicants will be pre-screened for indicators of program eligibility, if reasonable indicators of meeting program criteria is present, the ADRC will schedule face to face visit to assess the applicant's functional needs. If during the intake, the assessors discovers the applicant to not meet the PD program criteria, the assessor must take the following action if; The applicant has a primary diagnosis of I/DD, the assessor will must make a referral to the CDDO in which the applicant resides for evaluation.

If the applicant has a primary diagnosis of SPMI or SED, the assessor must make a referral to the CMHC for evaluation. The following criteria should be used to determine if the applicant may have a qualifying SPMI and should be referred to a CMHC:

a. 295.10 Schizophrenia, Disorganized Type
b. 295.20 Schizophrenia, Catatonic Type
c. 295.30 Schizophrenia, Paranoid Type
d. 295.60 Schizophrenia, Residual Type
e. 295.70 Schizoaffective Disorder
f. 295.90 Schizophrenia, Undifferentiated Type
g. 296.34 Major Depressive Disorder, Recurrent, Severe, with Psychotic Features

Bipolar I Disorders that are Severe, and/or with Psychotic Features

h. 298.9 Psychotic Disorder NOS

All Other Bipolar I Disorders, not listed in Category 1

i. 296.89 Bipolar II Disorder
j. 296.23 Major Depressive Disorder, Single Episode, Severe, Without Psychotic Features
k. 296.24 Major Depressive Disorder, Single Episode, With Psychotic Features
l. 296.32 Major Depressive Disorder, Recurrent, Moderate
m. 296.33 Major Depressive Disorder, Recurrent, Severe, Without Psychotic Features
n. 296.35 Major Depressive Disorder, Recurrent, In Partial Remission
o. 296.36 Major Depressive Disorder, Recurrent, In Full Remission

Delusional Disorder
p. 300.21 Panic Disorder With Agoraphobia
q. 300.3 Obsessive-Compulsive Disorder
r. 301.83 Borderline Personality Disorder

g. **Reevaluation Schedule.** Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

- ○ **Every three months**
- ○ **Every six months**
- ◉ **Every twelve months**
- ○ **Other schedule**

Specify the other schedule:

h. **Qualifications of Individuals Who Perform Reevaluations.** Specify the qualifications of individuals who perform reevaluations *(select one)*:

- ◉ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ○ **The qualifications are different.**

Specify the qualifications:

i. **Procedures to Ensure Timely Reevaluations.** Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care *(specify)*:

Timely re-evaluations are a component part of the state's contract with the ARDC. Both expectations and guidelines are specified in the waiver program's policies and procedures, which the contracted assessors must follow. Assurance is provided through ongoing contract monitoring and review, and quality reviews conducted by state or MCO staff.

j. **Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Written and/or electronically retrievable documentation of all evaluations and reevaluations is maintained by the ADRC. The state's contracting ADRC is using the state's KAMIS data base and the State's MIS.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Level of Care Assurance/Sub-assurances**

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. **Sub-Assurances:**

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of waiver participants who were determined to meet Level of Care requirements prior to receiving HCBS services N=Number of waiver participants who were determined to meet Level of Care requirements prior to receiving HCBS services D=Total number of enrolled waiver participants

Data Source (Select one):
Other
If 'Other' is selected, specify:
Operating Agency's data systems and Managed Care Organizations (MCOs) encounter data

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☑ **Other** Specify: Contracted assessors and Managed Care Organizations (MCOs)	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☑ State Medicaid Agency	☐ Weekly
☑ Operating Agency	☐ Monthly
☐ Sub-State Entity	☑ Quarterly
☑ Other Specify: Contracted assessors participate in analysis of this measure's results as determined by the State operating agency	☑ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of waiver paritipcants who receive their annual Level of Care evaluation within 12 months of the previous Level of Care determination N = Number of waiver participants who receive their annual Level of Care evaluation within 12 months of the previous Level of Care determination D = Number of waiver participants who received Level of Care determinations

Data Source (Select one):
Other
If 'Other' is selected, specify:
Operating agency's data systems: "Kansas Assessment Management Information (KAMIS) System or its related web applications"

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☑ State Medicaid Agency	☐ Weekly	☐ 100% Review
☑ Operating Agency	☐ Monthly	☑ Less than 100% Review

☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☑ **Other** Specify: Contracted assessors	☐ **Annually**	☑ **Stratified** Describe Group: Proportionate by MCO
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: Contracted assessors participate in analysis of this measure's results as determined by the State operating agency	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of initial Level of Care (LOC) determinations made where the LOC criteria was accurately applied N=Number of initial Level of Care (LOC) determinations made where the LOC criteria was accurately applied D=Number of initial Level of Care determinations

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☑ **Other** Specify: Contracted assessors	☐ **Annually**	☑ **Stratified** Describe Group: Proportionate by MCO
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☑ Operating Agency	☐ Monthly
☐ Sub-State Entity	☑ Quarterly
☑ Other Specify: Contracted assessors participate in analysis of this measure's results as determined by the State operating agency	☐ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:
Number and percent of initial Level of Care (LOC) determinations made by a qualified assessor N=Number of initial Level of Care (LOC) determinations made by a qualified assessor D=Number of initial Level of Care determinations

Data Source (Select one):
Other
If 'Other' is selected, specify:
Assessor and assessment records

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☐ State Medicaid Agency	☐ Weekly	☑ 100% Review
☑ Operating Agency	☐ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☐ Representative Sample Confidence Interval =
☑ Other Specify: Contracted assessors	☑ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:

	☐ Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☑ State Medicaid Agency	☐ Weekly
☑ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☑ Other Specify: Contracted assessors participate in analysis of this measure's results as determined by the State operating agency	☑ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:
Number and percent of waiver participants whose Level of Care (LOC) determinations used the state's approved screening tool N=Number of waiver participants whose Level of Care determinations used the approved screening tool D=Number of waiver participants who had a Level of Care determination

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☐ State Medicaid Agency	☐ Weekly	☐ 100% Review
☑ Operating Agency	☐ Monthly	☑ Less than 100% Review
☐ Sub-State Entity	☑ Quarterly	☑ Representative Sample Confidence Interval =

		95%
☑ **Other** Specify: Contracted assessors	☐ **Annually**	☑ **Stratified** Describe Group: Proportionate by MCO
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: Contracted assessors participate in analysis of this measure's results as determined by the State operating agency	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

These performance measures will be included as part of the comprehensive KanCare State Quality Improvement Strategy, and assessed quarterly with follow remediation as necessary. In addition, the performance of the functional eligibility contractors with Kansas will be monitored on an ongoing basis to ensure compliance with the contract requirements.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

These measures and collection/reporting protocols, together with others that are part of the KanCare MCO contract, are included in a statewide comprehensive KanCare quality improvement strategy which is regularly reviewed and adjusted. That plan is contributed to and monitored through a state interagency monitoring team, which includes program managers, contract managers, fiscal staff and other relevant staff/resources from both the state Medicaid agency and the state operating agency.
State staff request, approve, and assure implementation of contractor corrective action planning and/or technical assistance to address non-compliance with performance standards as detected through on-site monitoring, survey results and other performance monitoring. These processes are monitored by both contract managers and other relevant state staff, depending upon the type of issue involved, and results tracked consistent with the statewide quality improvement strategy and the operating protocols of the Interagency Monitoring Team.

ii. **Remediation Data Aggregation**

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: KanCare MCOs participate in analysis	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. **Timelines**
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

◉ **No**

○ **Yes**
Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. **Procedures.** Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

During the plan of care development process, the KanCare MCO selected by the consumer informs eligible consumers, or their legal representatives, of feasible alternatives for long-term care, and documents their choice of

either institutional or home and community-based waiver services utilizing the HCBS-PD Waiver Consumer Choice Form.

b. **Maintenance of Forms.** Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

HCBS/PD Waiver Consumer Choice forms are documented and maintained by the consumer's chosen KanCare MCO in the consumer's case file.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
KDADS has taken steps to assist staff in communicating with their Limited English Proficient Persons, and to meet the provisions set out in the Department of Health and Human Services Policy Guidance of 2000 requiring agencies which receive federal funding to provide meaningful access to services by Limited English Proficient Persons. In order to comply with federal requirements that individuals receive equal access to services provided by KDADS and to determine the kinds of resources necessary to assist staff in ensuring meaningful communication with Limited English Proficient consumers, states are required to capture language preference information. This information is captured in the state's KAMIS data base.

The State of Kansas defines prevalent non- English languages as languages spoken by significant number of potential enrollees and enrollees. Potential enrollee and enrollee materials will be translated into the prevalent non-English languages.

Each contracted provider is required by Kansas regulation to make every reasonable effort to overcome any barrier that consumers may have to receiving services, including any language or other communication barrier. This is achieved by having staff available to communicate with the participant in his/her spoken language, and/or access to a phone-based translation services so that someone is readily available to communicate orally with the consumer in his/her spoken language. (K.A.R. 30-60-15).

Access to a phone-based translation system is under contract with KDADS and available statewide.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. **Waiver Services Summary.** *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Service Type	Service
Statutory Service	Personal Care Services
Supports for Participant Direction	Financial Management Services
Other Service	Assistive Services
Other Service	Home-Delivered Meals Service
Other Service	Medication Reminder Services
Other Service	Personal Emergency Response System and Installation
Other Service	Sleep Cycle Support

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Statutory Service

Service:
Personal Care

Alternate Service Title (if any):
Personal Care Services

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Personal Care Service (PCS) is not available as a State plan service. The functions of a PCS includes but is not limited to assisting with activities of daily living ADLs (bathing, grooming, toileting, transferring), health maintenance activities (including but not limited to extension of therapies), feeding, mobility and exercises, socialization and recreation activities. The PCS supports the participant in accessing medical services and normal daily activities by accompanying the participant to accomplish tasks as listed within the scope of service in accordance with K.S.A 65-5115 and K.A.R. 28-51-113.
PCS can be provided and reimbursed based on the assessed needs of the participant as identified on the participant's Plan of Care (POC).
This service provides necessary assistance for individuals both in their home and community. Home is where the individual make his/her residence, and must not be defined as institutional in nature and must comply with the HCBS final rule setting. PCS may be provided in a setting where the individual lives with a family. A family is defined as any person immediately related to the participant, such as parents/ legal guardian, spouse; or when the participant lives with other persons capable of providing the care as part of the informal support system.
It is the expectation that waiver participants who need assistance with daily living (ADL) or independent activities of daily living (IADL) tasks and who live with persons capable of performing these tasks, should rely on these informal/natural supports for this assistance unless there are extenuating or specific circumstances that have been documented in the plans of care. In accordance with this expectation, PCS should not be used for lawn care, snow removal, shopping, ordinary housekeeping (as this is a task that can be completed in conjunction with the housekeeping/laundry done by the person with whom the recipient lives), or meal preparation during the times when the person with whom the recipient lives would normally prepare a meal for themselves. PCS may be reimbursed for preparation of a specialized diet that is designed specifically for the participant's dietary needs.
The service must occur in the home or community location meeting the setting requirements as defined in the

"HCBS Setting Final Rule". Service provided in a home school setting must not be educational in purpose. Services furnished to an individual who is an inpatient or resident of a hospital, nursing facility, intermediate care facility for persons with Intellectual Developmental Disability (IDD), or institution for mental disease are not covered.
PCS service will be coordinated by the KanCare MCO Care Manager and arranged for, and purchased under the individual or legally responsible party's written authority, and paid through an enrolled fiscal management service agent consistent with and not exceeding the individuals Plan of Care.
Individual or legally responsible individual with the authority to direct services who may at some point determine that they no longer want to participant-direct his/her service will have the opportunity to receive the previously approved waiver service, without penalty.
A PCS may not perform any duties not delegated by the participant or participant's representative with the authority to direct services or duties as approved by the participant's physician and must be identified as a necessary task in the plans of care. PCS may not be provided by the parent or legal guardian for the minor waiver Participant.
The cost associated with the provider traveling to deliver this service is included in the rate paid to the provider. Non-emergency Medical Transportation (NEMT) service is a state plan service and can be accessed through the participant's chosen KanCare MCO.
Participants under the age of 21 who are eligible to receive EPSDT services may access those services through the Medicaid state plan. PCS targeted for this population are non-duplicative of services provided under EPSDT.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Personal Care Services are limited to the individual's assessed level of service need, as specified in the participant's plan of care, not to exceed ten (10) hours per 24-hour time period. Personal Care Services can exceed the limitation established by the State given one or more of the following critical situations:
1. The participant is returning to the community from an institutional setting, i.e., nursing facility, rehabilitation facility, or other medical facility. Personal Care Services that exceed ten (10) hours per 24-hour time period must be critical to the participant's ability to return to and remain in the community. The duration is subject to medical necessity and approval by KanCare MCO.

2. Waiver participant is in a situation where there is:
• Confirmation by Adult Protective Services that the participant is a recent victim of abuse, neglect or exploitation, as defined in state policy;
• Confirmation by Children and Family Services that the participant is a recent victim of abuse or neglect, as defined in state policy;
• Documentation showing that the participant is a recent victim of domestic violence, as defined in state policy.
In each case, Personal Services must be critical to the remediation of the participant's abuse, neglect, exploitation, or domestic violence situation and be necessary for the participant to remain in the community.

3. Waiver participant has an assessed health and safety need that requires more than a total of ten (10) hours per 24-hour period and is at risk for institutional placement. Health and safety needs may include:
• two-person transfers,
• certain medical interventions,
• supervision for elopement that is likely to result in danger to the participant or others.

All participants are held to the same criteria when qualifying to exceed the limitation in accordance with statewide policies and guidelines. Children who may require Personal Services that do not meet the criteria may receive the service through the Medicaid State Plan if medically necessary.

All Personal Services will be arranged for, reviewed, and approved by the KanCare MCO's Care Coordinator with the participant's written authorization, and paid for through an enrolled home health agency, when services are agency-directed, or an enrolled Financial Management Services provider, when services are participant-directed. Payment for services must be made within the approved reimbursement range established by the state.

Participants may choose any qualified provider who can meet their Personal Services needs. An adult participant's spouse and a minor participant's parent, however, cannot be paid to provide Personal Services. Exceptions are made only if the service would be otherwise unavailable and/or the provision of Personal Services by that person is determined to be essential to the participant's health and well-being, in accordance with state regulation (K.A.R. 30-5-307).

Persons (including legal guardian, legally responsible person, or relative) who are directing or coordinating care on behalf of a participant may not provide Personal Services to that same participant.

A person may have several personal assistants providing him or her care on a variety of days at a variety of times, but a person may not have more than one assistant providing care at any given time. Plans of Care for which it is determined that the provision of Personal Services would be a duplication of services will not be approved. The MCO will not make payments for multiple claims filed for the same time on the same date of service.

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- ☑ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agency that provides Personal Services
Individual	Personal Care Attendant/Personal Services provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Personal Care Services

Provider Category:
Agency

Provider Type:
Home Health Agency that provides Personal Services

Provider Qualifications

License *(specify):*
K.S.A. 65-5001 et seq.

Certificate *(specify):*
N/A.

Other Standard *(specify):*
•Must be employed by and under the direct supervision of a home health agency licensed by the Kansas Department of Health and Environment, enrolled as a Medicaid provider and contracted with a KanCare MCO (In accordance with K.S.A 65-5115 and K.A.R. 28-51-113).
a. Must have a High School Diploma or equivalent;
b. Must be at least eighteen years of age or older;
c. Complete KDADS Approved Skill Training requirements.
d. Must reside outside of waiver recipient's home;
e. Complete any additional skill training needed in order care for the waiver recipient as recommended either by the participant or legal representative, qualified medical provider, or KanCare MCO.

All standards, certifications and licenses that are required for the specific field through which service is provided including but not limited to: professional license / certification if required; adherence to KDADS's training and professional development requirements; maintenance of clear background as evidenced through background checks of; KBI, APS,CPS, Nurse Aid Registry, and Motor Vehicle screen". Any provider found identified to have been substantiated for prohibited offenses as listed in KSA 39-970 & 65-5117 is not eligible for reimbursement of services under Medicaid funding.

Verification of Provider Qualifications

Entity Responsible for Verification:
KDHE/KDADS, through the state fiscal agent, and the KanCare MCOs.
Frequency of Verification:
As deemed necessary by KDHE/KDADS

Appendix C: Participant Services
C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Personal Care Services

Provider Category:
Individual

Provider Type:
Personal Care Attendant/Personal Services provider

Provider Qualifications

License *(specify):*
N/A

Certificate *(specify):*
N/A

Other Standard *(specify):*
Must be employed by and under the direct supervision of a home health agency licensed by the Kansas Department of Health and Environment, enrolled as a Medicaid provider and contracted with a KanCare MCO (In accordance with K.S.A 65-5115 and K.A.R. 28-51-113).
a. Must have a High School Diploma or equivalent;
b. Must be at least eighteen years of age or older;
c. Complete KDADS Approved Skill Training requirements.
d. Must reside outside of waiver recipient's home;
e. Complete any additional skill training needed in order care for the waiver recipient as recommended either by the participant or legal representative, qualified medical provider, or KanCare MCO.

All standards, certifications and licenses that are required for the specific field through which service is provided including but not limited to: professional license / certification if required; adherence to KDADS's training and professional development requirements; maintenance of clear background as evidenced through background checks of; KBI, APS,CPS, Nurse Aid Registry, and Motor Vehicle screen". Any provider found identified to have been substantiated for prohibited offenses as listed in KSA 39-970 & 65-5117 is not eligible for reimbursement of services under Medicaid funding.

Verification of Provider Qualifications

Entity Responsible for Verification:
KDHE/KDADS through the state fiscal agent; and KanCare MCOs.
Frequency of Verification:
As deemed necessary by KDHE/KDADS

Appendix C: Participant Services
C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

Support for Participant Direction:
Information and Assistance in Support of Participant Direction

Alternate Service Title (if any):
Financial Management Services

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- (◎) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Kansas is promoting true choice by making options available to the participant or responsible party by entering into an employment support with the Financial Management Services (FMS) provider and to work collaboratively with the FMS to ensure the receipt of quality, needed support services from direct support workers. The participant retains the primary responsibility as the common law employer. FMS service will be provided through a third party entity.
The MCO will ensure that persons seeking or receiving participant-directed services have been informed of the benefits and responsibilities of the participant-direction and provide the choice of FMS providers. The choice will be presented to the person initially at the time participant-direction is chosen and annually during his/her plan of care planning process, or at any time requested by the participant or the person directing services on behalf of the participant. The MCO is responsible for documenting the provider choice. In addition, The MCO will be responsible for informing the participant of the process for changing or discontinuing an FMS provider and the process for ending participant-direction. The MCO will be responsible for informing the participant that agency-directed services can be made at any time if the participant no longer desires to participant-direct his/her service(s).
The FMS provider will provide information regarding participant direction relating to employer responsibilities, including potential liabilities associated with participant direction. Participant-direction (K-PASS participant-direction tool kit) is available to all participants through the KDADS website. The participant and participant's representative are responsible for working collaboratively with their FMS provider to meet shared objectives. These objectives may include:
• Participant is receiving high quality services.
• Participant receives needed services from qualified workers.
• Tasks are provided in accordance with state law governing participant-direction, Medicaid and the State of Kansas requirements, and the plan of care is authorized by MCO.
FMS support is available for the participant (or the person assigned by the participant, such as a representative, family member, parent, spouse, adult child, guardian) who has chosen to participant-direct some or all services, to assist the participant by performing administrative and payroll functions. FMS support will be provided

within the scope of the Employer Authority model. The FMS is available to participants who reside in their own private residences or the private home of a family member and have chosen to participant-direct their services. FMS assists the participant or participant's representative by providing two distinct types of tasks: (1) Administrative Tasks and (2) Information and Assistance (I & A) Tasks. The FMS provider is responsible for certain administrative functions, tasks include, but are not limited to, the following:

• Verification and processing of time worked and the provision of quality assurance;

• Preparation and disbursement of qualified direct support worker payroll in compliance with federal, state and local tax; labor; and workers' compensation insurance requirements; making tax payments to appropriate tax authorities;

• Performance of fiscal accounting and expenditure reporting to the participant or participant's representative and the state, as required.

• Assistance to ensure the basic minimum qualifications set by the State are met in order to ensure participant safety, health and welfare.

Information and Assistance Responsibilities

1. Explanation of all aspects of participant-direction and subjects pertinent to the participant or participant's representative in managing and directing services;

2. Assistance to the participant or participant's representative in arranging for, directing and managing services;

3. Assistance in identifying immediate and long-term needs, developing options to meet those needs and accessing identified supports and services;

4. Offers practical skills training to enable participants or representatives to independently direct and manage waiver services such as recruiting and hiring direct service workers, managing workers, and providing effective communication and problem-solving.

This service does not duplicate other waiver services including case management. Where the possibility of duplicate provision of services exists, the participant plan of care shall clearly delineate responsibilities for the performance of activities.

In addition to the MCO's responsibility above, the FMS provider is also responsible for informing participant that he/she must exercise responsibility for making the choice to participant-direct his/her attendant care services, understand the impact of the choices made, and assume responsibility for the results of any decisions and choices that was made. The FMS is responsible for clearly communicating verbally and in writing the participants responsibilities relating his/her role as an employer of a direct service worker, the information and assistance provided, at a minimum must include the following:

• Act as the employer for Direct Support Workers (DSW), or designate a representative to manage or help manage Direct Support Workers. See definition of representative above.

• Negotiate a FMS Service Agreement with the chosen FMS provider that clearly identifies the roles and responsibilities of the participant and the FMS provider

• Establish the wage of the DSW(s)

• Select Direct Support Worker(s)

• Refer DSW to the FMS provider for completion of required human resources and payroll documentation. In cooperation with the FMS provider, all employment verification and payroll forms must be completed.

• Negotiate an Employment Service Agreement with the DSW that clearly identifies the responsibilities of all parties, including work schedule.

• Provide or arrange for appropriate orientation and training of DSW(s).

• Determine schedules of DSW(s).

• Determine tasks to be performed by DSW(s) and where and when they are to be performed in accordance with the approved and authorized POC or others as identified and/or are appropriate.

• Manage and supervise the day-to-day HCBS activities of DSW(s).

• Verify time worked by DSW(s) was delivered according to the POC; and approve and validate time worked electronically or by exception paper timesheets.

• Assure utilization of EVV system to record DSW time worked and all other required documents to the FMS provider for processing and payment in accordance with established FMS, State, and Federal requirements. The EVV/timesheet will be reflective of actual hours worked in accordance with an approved POC.

• Process for reporting work-related injuries incurred by DSW(s) to the FMS provider.

• Develop an emergency worker back-up plan in case a substitute DSW is ever needed on short notice or as a back-up (short-term replacement worker).

• Assure all appropriate service documentation is recorded as required by the State of Kansas HCBS Waiver program policies, procedures, or by Medicaid Provider Agreement.

• Inform the FMS provider of any changes in the status of DSW(s), such as changes of address or telephone number, in a timely fashion.

• Inform the FMS provider of the dismissal of a DSW within 3 working days.

• Inform the FMS provider of any changes in the status of the participant or participant's representative, such as

the participant's address, telephone number or hospitalizations within 3 working days.
• Participate in required quality assurance visits with MCOs, and State Quality Assurance Staff, or other Federal and State authorized reviewers / auditors.
FMS Provider Requirements
Enrolled FMS providers will furnish Financial Management Services according to Kansas model. The provider requirements will be published and placed on the Kansas Medical Assistance Program (KMAP) website and/or in the KanCare MCO provider manuals and websites.
Organizations interested in providing Financial Management Services (FMS) are required to submit a signed Provider Agreement to the State Operating Agency, KDADS, prior to enrollment to provide the service. The agreement identifies the waiver programs under which the organization is requesting to provide FMS and outlines general expectations and specific provider requirements. The agreement will be renewed annually and approval is subject to satisfactory completion of required financial audit. In addition, organizations are required to submit the following documents with the signed agreement:
• Community Developmental Disability Organization (CDDO) agreement (I/DD only)
• Secretary of State Certificate of Corporate Good Standing
• W-9 form
• Proof of Liability Insurance
• Proof of Workers Compensation insurance
• Copy of the most recent quarterly operations report or estimate for first quarter operations
• Financial statements (last 3 months bank statements or documentation of line of credit)
• Copy of the organization's Policies and Procedures manual, to include information that covers requirements listed in the FMS Medicaid Provider Manual.
o Including process for conducting background checks
o Process for establishing and tracking workers wage with the participant
The FMS provider agreement and accompanying documentation are reviewed by the State Operating Agency and all assurances are satisfied as part of a readiness review prior to signing by the Secretary of KDADS (or designee). KanCare MCOs should not credential any application without evidence of a fully executed FMS Provider agreement.
Payment for FMS
FMS providers will be reimbursed a monthly fee per member per month. The per member per month payment was estimated based upon a formula that included all direct and indirect costs to payroll agents and an average hourly rate for direct care workers. Information was gathered as part of a Systems Transformation Grant study conducted by Myers & Stauffer. Under the KanCare program, FMS providers will contract with MCOs for final payment rates, which cannot be less than the current FMS rate.
Limitations
Access to this service is limited to participants who chose to participant-direct some or all of the service(s) when participant-direction is offered.
FMS service is reimbursed per member per month. FMS service may be accessed by the participant at a minimum monthly or as needed in order to meet the needs of the participant. A participant may have only one FMS provider per month.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Access to this service is limited to participants who chose to participant-direct some or all of the service(s) when participant-direction is offered.
FMS service is reimbursed per member per month. FMS service may be accessed by the participant at a minimum monthly or as needed in order to meet the needs of the participant. A participant may have only one FMS provider per month.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Enrolled Medicaid Provider of Financial Management Services

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction
Service Name: Financial Management Services

Provider Category:
Agency

Provider Type:
Enrolled Medicaid Provider of Financial Management Services

Provider Qualifications

License *(specify):*
N/A

Certificate *(specify):*
N/A

Other Standard *(specify):*
Enrolled FMS providers will furnish Financial Management Services according to Kansas model. The provider requirements will be published and placed on the Kansas Medical Assistance Program (KMAP) website and/or in the KanCare MCO provider manuals and websites.
Organizations interested in providing Financial Management Services (FMS) are required to submit a signed Provider Agreement to the State Operating Agency, KDADS, prior to enrollment to provide the service. The agreement identifies the waiver programs under which the organization is requesting to provide FMS and outlines general expectations and specific provider requirements. The agreement will be renewed annually and approval is subject to satisfactory completion of required financial audit. In addition, organizations are required to submit the following documents with the signed agreement:
• Community Developmental Disability Organization (CDDO) agreement (I/DD only)
• Secretary of State Certificate of Corporate Good Standing
• W-9 form
• Proof of Liability Insurance
• Proof of Workers Compensation insurance
• Copy of the most recent quarterly operations report or estimate for first quarter operations
• Financial statements (last 3 months bank statements or documentation of line of credit)
• Copy of the organization's Policies and Procedures manual, to include information that covers requirements listed in the FMS Medicaid Provider Manual.
o Including process for conducting background checks
o Process for establishing and tracking workers wage with the participant
The FMS provider agreement and accompanying documentation are reviewed by the State Operating Agency and all assurances are satisfied as part of a readiness review prior to signing by the Secretary of KDADS (or designee). KanCare MCOs should not credential any application without evidence of a fully executed FMS Provider agreement.

Verification of Provider Qualifications

Entity Responsible for Verification:
Kansas Department of Health and Environment, KDADS and KanCare MCOs are responsible for ensuring the FMS provider met the approved standards.

Frequency of Verification:
At a minimum,annually or more frequently as deemed necessary by KDHE and KDADS.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Assistive Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Assistive Services are those services which meet an individual assessed need of a consumer with a disability by modifying or improving a consumer's home through environmental modifications or otherwise enhancing the consumer's ability to live independently in his/her home and community through the use of adaptive equipment. Tangible equipment or hardware such as technology assistance devices, adaptive equipment, or environmental modifications may be substituted for a Personal Service when it is identified as a cost-effective alternative on the consumer's Plan of Care.

Assistive Services may include such things as ramps; lifts; modifications to bathrooms and kitchens specifically related to accessibility; and specialized safety adaptations and assistive technology that improve mobility and communication and enhance overall independence. Modifications that add to the total square footage of the home are excluded from this benefit except when necessary to complete a modification (for example, in order to improve entrance/egress in a residence or to configure a bathroom to accommodate a wheelchair). Environmental modifications may only be purchased in rented apartments or homes when the landlord agrees in writing to maintain the modifications for a period of not less than three years, and will give first rent priority to tenants with physical disabilities. Home accessibility adaptations are not furnished to adapt living arrangements that are owned or leased by providers of waiver services.

Reimbursement for this service is limited to the consumer's assessed level of service and based on the annualized plan of care. All Assistive Services will be arranged by the KanCare managed care orgagnization chosen by the consumer, with the consumer's written authorization of the purchase. Consumers will have complete access to choose any qualified provider with consideration given to the most economical option available to meet the consumer's assessed needs. Provision of Assistive Services is arranged and paid for by the consumer's chosen KanCare managed care organization, or by the consumer's FMS provider. If a related vendor, such as a Durable Medical Equipment provider, does not wish to contract with the MCO or FMS

provider, the State shall provide a separate provider agreement which will allow the vendor to receive direct payment from Medicaid.

To avoid any overlap of services, Assistive Services are limited to those services not covered through regular State Plan Medicaid and which cannot be procured from other formal or informal resources (such as Vocational Rehabilitation, Rehabilitation Act of 1973, or the Educational System.) HCBS-PD waiver funding is used as the funding source of last resort and requires prior authorization from the consumer's chosen KanCare MCO.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Purchase is limited to a maximum lifetime expenditure of $ 7,500 per consumer, across all waivers.

Assistive Services are limited to the consumer's assessed level of service need, as specified in the consumer's Plan of Care, subject to critical situation criteria as established by the state. All consumers are held to the same criteria when qualifying for critical situation approval as in accordance with statewide policies and guidelines. Children who may require Assistive Services whose situation does not meet critical situation criteria may receive services through the Medicaid State Plan if medically necessary.

Effective January 1, 2010, Assistive Services is available, with prior authorization from the consumer's chosen KanCare MCO, to HCBS/PD waiver consumers for situations defined as "critical." The following three conditions must be met, applicable to the critical situation:
1. The Assistive Services purchase is critical to the remediation of the consumer's abuse, neglect, or exploitation., or
domestic violence issue;
2. The Assistive Services purchase Critical to the consumer's ability to remain in the community, AND
3. The Assistive Services purchase is a necessary expenditure within the first three months of the consumer's return to the
community.

Critical situations are defined as and limited to:
1. Consumer is a recipient of state policy MFP funding to access HCBS/PD or HCBS/TBI waiver services. The Assistive Services
purchase is critical to the consumer's ability to return to the community from the nursing facility and is a necessary
expenditure within the first three months of the consumer's return to the community. Planning for the use of any Assistive
Service shall occur prior to a person's return to the community, when applicable. In all cases, the consumer's chosen KanCare managed care organization must provide documentation that demonstrates how the Assistive Service is necessary to remediate the previously-described
situations.

2. Consumer previously left waiver services for a Planned Brief Stay, and the Assistive Services request is critical to the
consumer's ability to return to the community from the nursing facility or medical facility and is a necessary expenditure
within the first three months of the consumer's return to the community. Planning for the use of any Assistive Service
shall occur prior to a person's return to the community, when applicable. In all cases, the consumer's chosen KanCare managed care organization must
provide documentation that demonstrates how the Assistive Service is necessary to remediate the previously-described
situations.

3. Consumer's situation has met the criteria for, and there has been an DCF confirmation outcome of one of the following
situations:
a. An Adult Protective Services investigation outcome of abuse, neglect or exploitation; or
b. A Children and Family Services investigation outcome of abuse or neglect.
---OR---
c. The consumer is a recent victim of documented domestic violence.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Durable Medical Equipment provider
Individual	Contractor

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Assistive Services

Provider Category:
Agency

Provider Type:
Durable Medical Equipment provider

Provider Qualifications

License *(specify)*:
N/A

Certificate *(specify)*:
N/A

Other Standard *(specify)*:
- As described in K.A.R. 30-5-59
- Medicaid-enrolled provider
- Applicable work must be performed according to local and county codes

Verification of Provider Qualifications

Entity Responsible for Verification:
Kansas Department of Health and Environment (KDHE), through the state fiscal agent; and KanCare MCOs.

Frequency of Verification:
As determined by KDHE.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Assistive Services

Provider Category:
Individual

Provider Type:
Contractor

Provider Qualifications

License *(specify)*:
N/A

Certificate *(specify)*:
N/A

Other Standard *(specify):*
- Must affiliate with a recognized Center for Independent Living or licensed home health agency (as defined in K.S.A. 65-5001 et seq.).
- Applicable work must be performed according to local and county codes

Verification of Provider Qualifications

Entity Responsible for Verification:
Kansas Department of Health and Environment (KDHE), through the state fiscal agent; and KanCare MCOs.

Frequency of Verification:
As deemed necessary by KDHE

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Home-Delivered Meals Service

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- (◉) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Home-Delivered Meals service provides a consumer with one (1) or two (2) meals per calendar date. Each meal will contain at least one-third (1/3) of the recommended daily nutritional requirements. The meals are prepared elsewhere and delivered to a consumer's residence. Consumers eligible for this service have been determined functionally in need of the Home-Delivered Meals service as indicated by the functional eligibility assessment

instrument. Meal preparation by Physical Disability (PD) waiver Personal Care Services providers may be authorized in the Plan of Care for those meals not provided under the Home-Delivered Meal service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

- Providers of this service must have on staff or contract with a certified dietician to assure compliance with Kansas Department on Aging (KDOA) nutrition requirements for programs under the Older Americans Act.
- This service is limited to consumers who require extensive routine physical support for meal preparation as supported by the consumer's functional eligibility instrument for meal preparation.
- This service may NOT be maintained when a consumer is admitted to a nursing facility or acute care facility for a planned brief stay time period not to exceed two months following the admission month in accordance with Medicaid policy.
- This service is not duplicative of home-delivered meal service provided through the Older Americans Act, subject to the consumer meeting related age and other eligibility requirements, nor is it duplicative of meal preparation provided by attendants through Personal Services.
- This service is available in the consumer's place of residence, excluding assisted living and Home Plus facilities.
- No more than two (2) home-delivered meals will be authorized per consumer for any given calendar date.
- This service must be authorized in the consumer's Plan of Care.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Approved and Medicaid-enrolled nutrition provider agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home-Delivered Meals Service

Provider Category:
Agency

Provider Type:
Approved and Medicaid-enrolled nutrition provider agency

Provider Qualifications

License *(specify)*:
N/A

Certificate *(specify)*:
N/A

Other Standard *(specify)*:
Provider must have on staff or contract with a certified dietician to assure compliance with Kansas Department on Aging (KDOA) nutrition requirements for programs under the Older Americans Act.

Verification of Provider Qualifications

Entity Responsible for Verification:
Kansas Department on Aging (KDOA), an Area Agency on Aging (AAA), Kansas Department of Health and Environment (KDHE), through the state fiscal agent)

Frequency of Verification:
As deemed necessary by KDOA, an Area Agency on Aging, and KDHE

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Medication Reminder Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- (◉) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Medication Reminder Services provides a scheduled reminder to a participant when it is time for the participant to take medications. The reminder may be a phone call, automated recording, or automated alarm depending on the providers system.

Medication Reminder/Dispenser is a device that houses a participant's medication and dispenses the medication with an alarm at programmed times.

Medication Reminder/Dispenser Installation is the placement of the Medication Dispenser in a participant's home.

Education and assistance with all Medication Reminder Services is made available to participants during implementation and on an ongoing basis by the provider of this service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

-Maintenance of rental equipment is the provider's responsibility.
-Repair/replacement of rental equipment is not covered.
-Rental of equipment is covered.
-Purchase of equipment is not covered.

This service is limited to participants who live alone or who are alone a significant portion of the day, and have no regular informal and/or formal support for extended periods of time, and who otherwise require extensive routine non-physical support including medication reminder services offered through an attendant of Personal Services.

This service is not duplicative of services offered free of charge through any other agency or service. These systems may be maintained on a monthly rental basis even if a participant is admitted to a nursing facility or acute care facility for a planned brief stay time period not to exceed two months following the admission month in accordance with Medicaid policy.

This service is available in the participant's home. Medication Reminder service is not provided face-to-face with the exception of the Installation of Medication Reminder/Dispenser.

Installation of Medication Reminder/Dispenser is limited to one installation per consumer per calendar year.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Medication Reminder Services Provider/Dispenser Provider/ and Installation Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Medication Reminder Services

Provider Category:
Agency
Provider Type:
Medication Reminder Services Provider/Dispenser Provider/ and Installation Provider
Provider Qualifications
License *(specify)*:
N/A
Certificate *(specify)*:
N/A
Other Standard *(specify)*:
Any company providing Medication Reminder services per industry standards is eligible to enroll as a Medicaid provider of Medication Reminder Services.
Verification of Provider Qualifications
Entity Responsible for Verification:
Kansas Department of Health and Environment (KDHE), through the state fiscal agent; and KanCare MCOs.
Frequency of Verification:
As deemed necessary by KDHE.

Appendix C: Participant Services
C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Personal Emergency Response System and Installation

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- (◉) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Personal Emergency Response Systems (PERS) involve the use of electronic devices which enable certain consumers at high risk of institutionalization to secure help in an emergency. The consumer may also wear a portable "help" button to allow for mobility. The system is connected to the consumer's telephone and programmed to signal a response center once the "help" button is activated. PERS is limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular attendant (formal or informal) for extended periods of time, and who would otherwise require extensive routine supervision.

PERS Installation is the placement of electronic PERS devices in a consumer's residence. PERS installation is for those certain consumers at high risk of institutionalization to secure help in an emergency. These consumers have met the assessed need of a Personal Emergency Response System.

To avoid any overlap of services, PERS is limited to those services not covered through regular State Plan Medicaid and which cannot be procured from other formal or informal resources. HCBS-PD waiver funding is

used as the funding source of last resort and requires prior authorization from the consumer's chosen KanCare MCO.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

- Maintenance of rental equipment is the responsibility of the provider.
- Repair/replacement of equipment is not covered.
- Rental of the PERS System is covered; purchase is not.
- Call lights do not meet this definition.
- Maximum of two PERS Installations per calendar year.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	PERS and PERS Installation provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Emergency Response System and Installation

Provider Category:
Agency

Provider Type:
PERS and PERS Installation provider

Provider Qualifications

License *(specify)*:
N/A

Certificate *(specify)*:
N/A

Other Standard *(specify)*:

- Must be an enrolled Medicaid provider.
- Must conform to industry standards and any federal, state, and local laws and regulations that govern this service.
- The emergency response center must be staffed on a 24 hour/7 days a week basis by trained personnel.

Verification of Provider Qualifications

Entity Responsible for Verification:
Kansas Department of Health and Environment, (KDHE), through the state fiscal agent

Frequency of Verification:
As deemed necessary by KDHE

Appendix C: Participant Services
C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Sleep Cycle Support

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- ◉ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Sleep Cycle Support provides non-nursing physical assistance and/or supervision during the consumer's normal sleeping hours in the consumer's place of residence. This assistance includes, but is not limited to the following: (1) physical assistance or supervision with toileting, transferring, turning, intake of liquids, mobility issues, and (2) prompting to take medication

Providers will sleep and awaken as identified on the consumer's Plan of Care and must provide the consumer with a mechanism to gain their attention or awaken them at anytime (e.g., a bell or buzzer). Providers must be ready to call a physician, hospital, any identified contact individuals, or other medical personnel should an emergency occur. The scope of and intent behind Sleep Cycle Support is entirely different from and therefore not duplicative of services defined as and provided under Personal Services.

The Plan of Care must indicate a need for this service that is beyond the need for a Personal Emergency Response System.

To avoid any overlap of services, Sleep Cycle Support is limited to those services not covered through regular State Plan Medicaid and which cannot be procured from other formal or informal resources. HCBS-PD waiver funding is used as the funding source of last resort and requires prior authorization from the consumer's chosen KanCare MCO.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The length of service (i.e., one unit) during any 24-hour time period must be at least six (6) hours, but cannot exceed twelve (12) hours.

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- ☑ **Legally Responsible Person**
- ☑ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Sleep Cycle Support provider
Agency	Home Health Agency that provides Sleep Cycle Support

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Sleep Cycle Support

Provider Category:
Individual

Provider Type:
Sleep Cycle Support provider

Provider Qualifications

License *(specify)*:
N/A

Certificate *(specify)*:
N/A

Other Standard *(specify)*:
Must be employed by and under the direct supervision of a home health agency licensed by the Kansas Department of Health and Environment, enrolled as a Medicaid provider and contracted with a KanCare MCO (In accordance with K.S.A 65-5115 and K.A.R. 28-51-113).
a. Must have a High School Diploma or equivalent;
b. Must be at least eighteen years of age or older;
c. Complete KDADS Approved Skill Training requirements.
d. Must reside outside of waiver recipient's home;
e. Complete any additional skill training needed in order care for the waiver recipient as recommended either by the participant or legal representative, qualified medical provider, or KanCare MCO.

All standards, certifications and licenses that are required for the specific field through which service is provided including but not limited to: professional license / certification if required; adherence to KDADS's training and professional development requirements; maintenance of clear background as evidenced through background checks of; KBI, APS,CPS, Nurse Aid Registry, and Motor Vehicle screen". Any provider found identified to have been substantiated for prohibited offenses as listed in KSA 39-970 & 65-5117 is not eligible for reimbursement of services under Medicaid funding.

Verification of Provider Qualifications

Entity Responsible for Verification:
KDHE/KDADS, through the state fiscal agent; and, KanCare MCOs.

Frequency of Verification:

As deemed necessary by KDHE/KDADS

Appendix C: Participant Services
C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Sleep Cycle Support

Provider Category:
Agency
Provider Type:
Home Health Agency that provides Sleep Cycle Support
Provider Qualifications
License *(specify):*
As defined by K.S.A. 65-5001 et seq.
Certificate *(specify):*
N/A
Other Standard *(specify):*
Must be employed by and under the direct supervision of a home health agency licensed by the Kansas Department of Health and Environment, enrolled as a Medicaid provider and contracted with a KanCare MCO (In accordance with K.S.A 65-5115 and K.A.R. 28-51-113).
a. Must have a High School Diploma or equivalent;
b. Must be at least eighteen years of age or older;
c. Complete KDADS Approved Skill Training requirements.
d. Must reside outside of waiver recipient's home;
e. Complete any additional skill training needed in order care for the waiver recipient as recommended either by the participant or legal representative, qualified medical provider, or KanCare MCO.

All standards, certifications and licenses that are required for the specific field through which service is provided including but not limited to: professional license / certification if required; adherence to KDADS's training and professional development requirements; maintenance of clear background as evidenced through background checks of; KBI, APS,CPS, Nurse Aid Registry, and Motor Vehicle screen". Any provider found identified to have been substantiated for prohibited offenses as listed in KSA 39-970 & 65-5117 is not eligible for reimbursement of services under Medicaid funding.

Verification of Provider Qualifications
Entity Responsible for Verification:
KDHE/KDADS, through the state fiscal agent; and KanCare MCOs.
Frequency of Verification:
As deemed necessary by KDHE/KDADS

Appendix C: Participant Services
C-1: Summary of Services Covered (2 of 2)

b. **Provision of Case Management Services to Waiver Participants.** Indicate how case management is furnished to waiver participants (*select one*):

◉ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.

○ **Applicable** - Case management is furnished as a distinct activity to waiver participants.
Check each that applies:
☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
☐ **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*

☐ **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*

☐ **As an administrative activity.** *Complete item C-1-c.*

c. **Delivery of Case Management Services.** Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. **Criminal History and/or Background Investigations.** Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

○ **No. Criminal history and/or background investigations are not required.**

◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

The contractor / sub contactor and /or provider agency must complete a background check to include the following: Kansas Bureau of Investigations (KBI), APS, CPS, KSBN, nurse aide registry, and motor vehicle screen on performing employee for the following waiver services:
-Personal Services
-Financial Management Services
-Sleep Cycle Support

The contractor / sub contactor and /or provider agency must provide evidence that required standards have been met or maintained at the renewal of their professional license. These standards may be reviewed by KDADS Regional Field Staff at the time of their reviews and sooner if a potential problem is identified. At any time deemed appropriate by KDADS, a license or certification, if applicable may be formally reviewed by KDADS to determine whether the licensee continues to be in compliance with the waiver service requirements. Providers must submit the above documentation along with qualifications to the HCBS- TBI Waiver Program Manager for review in order to become an enrolled Medicaid provider of HCBS-TBI Waiver services.

b. **Abuse Registry Screening.** Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

○ **No. The State does not conduct abuse registry screening.**

◉ **Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The contractor / sub contactor and /or provider agency must complete a background check on the performing employee against the Kansas Department for Children and Family (DCF) child and adult abuse registries. DCF maintains the registries for all confirmed perpetrators. Providers of services identified below must undergo an abuse registry screening in addition to maintaining a clear background check as specified in the provider qualifications.
-Financial Management Services
-Personal Services

Waiver Service	Provided in Facility
Medication Reminder Services	☐
Personal Emergency Response System and Installation	☐
Personal Care Services	☑
Assistive Services	☑
Sleep Cycle Support	☐

Facility Capacity Limit:

Six (6) or more

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards	
Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : resident ratios	☑
Staff training and qualifications	☑
Staff supervision	☑
Resident rights	☑
Medication administration	☑
Use of restrictive interventions	☑
Incident reporting	☑
Provision of or arrangement for necessary health services	☑

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

N/A

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Home Plus

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Financial Management Services	☐
Home-Delivered Meals Service	☐
Medication Reminder Services	☐

of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

Legally responsible individuals may be reimbursed when providing Personal Services and/or Sleep Cycle Support services. State regulations specify, however, that neither an adult participant's spouse nor a minor participant's parent shall be paid to provide HCBS services to that participant, unless all other possible options are exhausted and one of the following extraordinary criteria is met:
• The MCO will provide written documentation that the participant's residence is so remote or rural that HCBS services are otherwise completely unavailable.
• Two health care professionals, including the attending physician, furnish written documentation that the participant's health, safety, or social well-being would be jeopardized.
• The attending physician furnishes written documentation that, due to the advancement of chronic disease, the participant's means of communication can be understood only by the spouse or by the parent of a minor child.
• The MCO will furnish written documentation that delivery of HCBS services to the participant poses serious health or safety issues for the provider, thereby rendering HCBS services otherwise unavailable. (K.A.R. 30-5-307)

Legally responsible individuals, including legal, adjudicated guardians may provide personal services although they must contract with KanCare or have an arrangement with an KanCare contracted provider that includes TBI Personal Services and/or Sleep Cycle Support as a service specialty. This allowance in no way supersedes the family reimbursement restriction pertaining to spouses and parents of minor children noted above. Limitation on services is governed by the assessed need of the participant.

Assurance that payments are made only for services rendered is provided through documentation on time sheets by the personal care services provider. Other assurance is provided through periodic reviews conducted by the Surveillance and Utilization Review System unit of the state's contracted fiscal agent.

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

○ **The State does not make payment to relatives/legal guardians for furnishing waiver services.**

◉ **The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

Relatives other than spouses or parents of minor children may be providers of Personal care services and/or Sleep Cycle Support. An individual acting on behalf of a new consumer or the holder of the new consumer's activated Durable Power of Attorney for Health Care Decisions cannot be the consumer's paid Personal Care Attendant (PCA). If the designation of the appointed representative is withdrawn, the individual may become the consumer's paid PCA after the next annual review or a significant change in the consumer's needs occurs prompting a reassessment.

Relatives as consumer attendants can be in the best interest of the consumer when those individuals are the only ones available to provide attendant care and/or when those individuals are the best source of knowledge regarding the consumers' specific issues, whether the issues are health, function, and/or behavioral in nature. Assurance that services provided by relatives is in the best interest of consumers is done by consumer report in periodic review of KDADS Field staff as well as ongoing monitoring by the consumer's chosen KanCare MCO.

When an individual acting on behalf of the consumer is the holder of the consumer's Durable Power of Attorney for Health Care Decisions and is also the consumer's PCA, the consumer's KanCare MCO must complete a home visit at least every three months to ensure that the selected care giver is performing the necessary services.

A consumer who has been adjudicated as needing a guardian and/or conservator cannot choose to self-direct his/her care. The participant's guardian and/or conservator may choose to self-direct the consumer's care. However, an adult consumer's legal guardian and/or conservator cannot act as the consumer's paid Personal Care Attendant (PCA).

Limitations on the amount of services are governed by the assessed need of the consumer and monitored by the consumer's KanCare MCO. In addition, assurance that services provided by a relative/legal guardian are in the best interests of the consumer are monitored in periodic review by KDADS Field staff as well as ongoing monitoring by the consumer's chosen KanCare MCO. Assurance that payments are made only for services rendered provided through the KanCare MCOs' corporate compliance/program integrity activities, as well as monitoring and review of fraud, abuse and waste activities/outcomes via the state's Quality Improvement Strategy.

○ **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

○ **Other policy.**

Specify:

f. **Open Enrollment of Providers.** Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Consumers of HCBS-PD waiver services have the right to choose who provides their services, within established guidelines regarding provider qualifications. Any qualified provider of those services may enroll through the Medicaid agency, Kansas Department of Health and Environment, (KDHE), for the Kansas Medical Assistance Program; and also must contract with, and meet the contracting terms of, the KanCare MCOs.

In addition to broadscale information and outreach by the state and the KanCare MCOs for all Medicaid providers, the providers that support HCBS waiver members have received additional outreach, information, transition planning and education regarding the KanCare program, to ensure an effective and smooth transition. In addition to the broader KanCare provider outreach (including educational tours and weekly stakeholder update calls), the providers that support HCBS waiver members have had focused discussions with state staff and MCO staff about operationalizing the KanCare program; about transition planning (and specific flexibility to support this) for the shift of targeted case management into MCO care management; and about member support in selecting their KanCare plan. The requirements, procedures and timeframes to quality have been clearly communicated via state and MCO information development and outreach as described above, and also via standardized credentialing applications and state-approved contracts which MCOs offered to each existing provider; and related information, including provider manuals has been made available via state and MCO websites.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Qualified Providers**

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. **Sub-Assurances:**

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number/percent of new licensed/certified waiver provider applicants that initially met licensure,certification requirements, and other waiver standards prior to furnishing waiver services N=Number of new licensed/certified waiver provider applicants that initially met licensure requirements, etc. prior to furnishing waiver services D=Number of all new licensed/certified waiver providers

Data Source (Select one):
Other
If 'Other' is selected, specify:
Managed Care Organization (MCO) reports and record reviews

Responsible Party for data	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

collection/generation *(check each that applies):*		
☑ State Medicaid Agency	☐ Weekly	☐ 100% Review
☑ Operating Agency	☐ Monthly	☑ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☑ Representative Sample Confidence Interval = 95%
☑ Other Specify: KanCare Managed Care Organizations (MCOs)	☐ Annually	☑ Stratified Describe Group: Proportionate by MCO
	☑ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☑ State Medicaid Agency	☐ Weekly
☑ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☑ Other Specify: KanCare MCOs participate in analysis of this measure's results as determined by the State operating agenccy	☑ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:

Number and percent of enrolled licensed/certified waiver providers that continue to meet licensure requirements, certification requirements, and other waiver standards N=Number of enrolled licensed/certified waiver providers that continue to meet licensure requirements, certification requirements, and other waiver standards D=Number of enrolled licensed/certified waiver providers

Data Source (Select one):
Other
If 'Other' is selected, specify:
Managed Care Organization (MCO) reports and record reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☑ **Other** Specify: KanCare Managed Care Organizations (MCOs)	☐ **Annually**	☑ **Stratified** Describe Group: Proportionate by MCO
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other**	☑ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
Specify: KanCare MCOs participate in analysis of this measure's results as determined by the State operating agenccy	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of new non-licensed/non-certified waiver provider applicants that have met the initial waiver requirements prior to furnishing waiver services N=Number of new non-licensed/non-certified waiver provider applicants that have met the initial waiver requirements prior to furnishing waiver services D=Number of all new non-licensed/non-certified providers

Data Source (Select one):
Other
If 'Other' is selected, specify:
Managed Care Organization (MCO) reports and record reviews

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☑ **Other** Specify:	☐ **Annually**	☑ **Stratified**

KanCare Managed Care Organizations (MCOs)		Describe Group: Proportionate by MCO
	☑ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*
☑ State Medicaid Agency	☐ Weekly
☑ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☑ Other Specify: KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency	☑ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:
Number and percent of non-licensed/non-certified waiver providers that continue to meet waiver requirements N=Number of non-licensed/non-certified waiver providers that continue to meet waiver requirements D=Number of non-licensed/non-certified waiver providers

Data Source (Select one):
Other
If 'Other' is selected, specify:
Managed Care Organization (MCO) reports and record reviews

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☑ State Medicaid Agency	☐ Weekly	☐ 100% Review

☑ Operating Agency	☐ Monthly	☑ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☑ Representative Sample Confidence Interval = 95%
☑ Other Specify: KanCare Managed Care Organizations (MCOs)	☐ Annually	☑ Stratified Describe Group: Proportionate by MCO
	☑ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☑ State Medicaid Agency	☐ Weekly
☑ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☑ Other Specify: KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency	☑ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

c. ***Sub-Assurance:*** ***The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of active providers that meet training requirements
N=Number of providers that meet training requirements D=Number of active providers

Data Source (Select one):
Other
If 'Other' is selected, specify:
Managed Care Organization (MCO) reports and record reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☑ **Other** Specify: KanCare Managed Care Organizations (MCOs)	☐ **Annually**	☑ **Stratified** Describe Group: Proportionate by MCO
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☑ State Medicaid Agency	☐ Weekly
☑ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☑ Other Specify: KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency	☑ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
These measures and collection/reporting protocols, together with others that are part of the KanCare MCO contract, are included in a statewide comprehensive KanCare quality improvement strategy which is regularly reviewed and adjusted. That plan is contributed to and monitored through a state interagency monitoring team, which includes program managers, fiscal staff and other relevant staff/resources from both the state Medicaid agency and the state operating agency.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
State staff request, approve, and assure implementation of contractor corrective action planning and/or technical assistance to address non-compliance with performance standards as detected through on-site monitoring, MCO compliance monitoring, survey results and other performance monitoring. These processes are monitored by both contract managers and other relevant state staff, depending upon the type of issue involved, and results tracked consistent with the statewide quality improvement strategy and the operating protocols of the Interagency Monitoring Team.

ii. **Remediation Data Aggregation**

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*
☑ State Medicaid Agency	☐ Weekly
☑ Operating Agency	☐ Monthly
☐ Sub-State Entity	☑ Quarterly
☑ Other Specify: KanCare Managed Care Organizations (MCOs)	☐ Annually
	☑ Continuously and Ongoing

Responsible Party(*check each that applies*):	Frequency of data aggregation and analysis (*check each that applies*):
	☐ Other Specify:

c. **Timelines**
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

◉ **No**

○ **Yes**
Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services
C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services
C-4: Additional Limits on Amount of Waiver Services

a. **Additional Limits on Amount of Waiver Services.** Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

◉ **Not applicable**- The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

○ **Applicable** - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.

Furnish the information specified above.

☐ **Other Type of Limit.** The State employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:
Individual Plan of Care (POC)

a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

☐ **Registered nurse, licensed to practice in the State**
☐ **Licensed practical or vocational nurse, acting within the scope of practice under State law**
☐ **Licensed physician (M.D. or D.O)**
☐ **Case Manager** (qualifications specified in Appendix C-1/C-3)
☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
Specify qualifications:

☐ **Social Worker**
Specify qualifications:

☑ **Other**
Specify the individuals and their qualifications:

Kansas has contracted with three managed care organizations, to provide overall management of these services as one part of the comprehensive KanCare program. The MCOs are responsible for plan of care development, and will be using their internal staff to provide that service. Kansas requires that conflict of interest be

mitigated, and recognizes that the primary way in which that mitigation has been achieved is by separating from service providers the plan of care developmenting, and making that an MCO function. (In addition, conflict has been mitigated by Kansas separating the level of care determination from any service delivery or plan of care development.) Some of the additional safeguards that will be in place to ensure that there is no conflict of interest in this function include the operational strategies for each MCO that are described in detail at Section D.1.d of this appendix.

Regarding Amerigroup: Service plans for Amerigroup members in waivers are developed by Service Coordinators who must have at least two years of experience working with individuals with chronic illness, comorbidities, and/or disabilities in a Service Coordinator, Case Management, Advocate or similar role. Preferred qualifications include experience in home health, health care, discharge planning, behavioral health, collaborating with nursing facilities, community resources, and/or other home and community-based agencies. Experience working with Medicare, Medicaid and managed care programs is also preferred.

While a Masters degree is preferred, education/experience for Service Coordinators must include one of the following

- Bachelors degree from an accredited college or university in Nursing, Social Work, Counseling, Special Education, Sociology, Psychology, Gerontology, or a closely related field, or State Waiver;
- Bachelors Degree in an unrelated field and at least two years of geriatric experience; or
- In lieu of a bachelor's degree, six years of case management experience

Regarding Sunflower: Sunflower employs an Integrated Care Team approach for Service Plan Development. Teams conducting care coordination/care management are generally comprised of multidisciplinary clinical and nonclinical staff. This integrated approach allows non-medical personnel to perform non-clinical based service coordination and clerical functions, and permits the licensed professional staff to focus on the more complex and clinically based service coordination needs. Care Managers have primary responsibilty for ensuring service plan development. Care managers are Registered Nurses and Master's level Behavioral Health clinicians with care management experience and, as applicable to the position, expertise including adult and pediatric medical, maternity and behavioral health/psychiatric care. Each Member receiving Care Management is assigned a lead Care Manager who oversees the Member's care. This includes, but is not limited to, participation in inpatient rounds with concurrent review nurses to assist with discharge and transitional care planning, and coordination with the Member's treating providers. Care Managers perform assessments, work with Members/caregivers to develop care plans, and provide educational resources and follow up in conjunction with the Integrated Care Team.

Regarding United: Service plans are developed by licensed nurses or licensed social workers.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

- ◉ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- ○ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

Each participant found eligible for HCBS/PD waiver services can choose to receive services through the waiver program. The MCO is responsible for for providing service options through the HCBS/PD waiver. The participant's choice of service options is indicated on the Consumer Choice form or on the plan of care (POC).

For development of the POC, the MCO provides information on the waiver services available to the participant. The participant, MCO, and participant-authorized representatives will determine the appropriate services for the POC. Participants will be given free choice of all qualified providers of each service included in his/her written POC. The MCO presents each eligible participant a list of providers from which the participant can choose for self-directed services, if self-direction is available, and a list of service providers for agency-directed services. The MCO assists the participant with accessing information and supports from the participant's chosen provider.

The participant has the authority to determine the parties that he/she chooses to be involved in the development of the POC. The MCO is responsible for involving all parties authorized by the participant of the date, time, and location of the plan development meeting. MCOs are trained on the civil rights of individuals with disabilities and independent living philosophy to ensure that consumer choice is involved in the plan development process. This approach is reinforced through regulation (K.A.R. 30-5-309) which requires participant involvement in the development of the POC.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. **Service Plan Development Process.** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

All applicants for program services must undergo an assessment to determine functional eligibility for the program. The Functionally Eligibility Instrument (FEI) is utilized to determine the Level of Care eligibility for the HCBS program. The state's eligibility contractor conducts the assessment of the applicant within five (5) working days of the referral, unless a different timeframe is requested by the applicant or his/her legal representative, if appropriate. Participants are informed of services options available through the program by the MCO during the process of plan of care development. The participant will indicate his/her choice to receive home and community based services on the Participant Choice Form of the Plan of Care (POC). This information is revisited by the MCO during the plan development process and specific services are identified that will best meet the participant's needs. During the plan of care development, the MCO will complete a needs assessment for the participant that will identify the necessary services to meet the needs of the participant.

The Plan of Care (POC) is developed during a face-to-face meeting with the participant, guardian (if applicable), the MCO and any selected representatives that the participant chooses to be involved. The location of the meeting is normally in the participant's home but arrangements can be made for another location if the participant desires. Date and time is always coordinated based on the convenience of the participant and the participant's representative, if applicable. The initial POC must be developed within seven (7) working days of financial eligibility determination and must include the MCO informing the participant of all available service options and providers for whom the participant can access. The development of the POC is finalized upon participant review and signed authorization. A copy of the POC developed during the face-to-face meeting will be provided to the participant at the time of the meeting. The participant must sign an acknowledgement that the MCO has informed him/her of all service options and available providers of those services. Services provided are based upon the needs of the participant identified through the needs assessment and clearly documented on the participant's Plan of Care (POC). The in-person health plan, needs assessment, and plan of care must be completed to allow the participant to begin receiving services within fourteen (14) working days of financial eligibility determination.

The MCO must have a face-to-face meeting with the participant, guardian (if applicable), and any selected representatives every six (6) months. During this face-to-face meeting, the POC will be reviewed and updated in accordance with the participant's current needs. Any change to services needs requires a new POC be completed. A

participant requesting a change of provider must inform MCO and allow thirty (30) days for the transition unless extenuating circumstance (i.e. ANE). The POC will be updated in accordance with the participant's change in provider. For each service change the POC must be signed or resigned by both the MCO and the participant or participant's representative.

A participant's POC is developed based on the information gathered from the following:
- Functional Eligibility Assessment
- Needs Assessment
- Health Assessment, if applicable

The participant's POC takes into account information gathered from the Functional Eligibility Instrument, which identify potential risk factors. The POC will document the types of services to be furnished, the amount, frequency, and duration of each service, and the type of provider to furnish each service (including informal services and providers).

With the participant's approval, family participants or other individuals designated by the participant are encouraged to participate, to the greatest extent possible, in the development and implementation of the POC. If the participant has a court appointed guardian/conservator or an activated durable power of attorney for health care decisions, the guardian/conservator or the holder of the activated durable power of attorney for health care decisions must be included and all necessary signatures documented on POC. The participant's desired outcomes and preferences are discussed when determining the services to be included in the POC.

It is the expectation that program participants who need assistance with daily living (ADL) or independent activities of daily living (IADL) tasks and who live with persons capable of performing these tasks, should rely on these informal/natural supports for this assistance unless there are extenuating or specific circumstances that have been documented in the plan of care. The participant's available natural/informal supports and services provided by the natural supports must be clearly reported on the needs assessment and POC.

The MCO completes the appropriate forms indicating service tasks necessary to enable the participant to live safely in the most integrated environment possible. A physician's statement may be required if there is any question about cognitive impairments. An individual who is cognitively impaired may have difficulty self-directing as the individual may have difficulty communicating his/her needs and wants. A physician's statement is required if the participant elects to self-direct attendant care and requires health maintenance tasks or medication set-up.

The MCO must inform the providers the rate of services and discuss the hours of care to be delivered to the participant.

The MCO shall record all pertinent information received verbally or in writing from the participant, staff or collateral contacts in the case log. The MCO shall send the POC, the identified service tasks to be performed indicated from the needs assessment, and Notice of Action (NOA) to all involved parties, i.e., the participant, providers, activated durable power of attorney, guardian, and conservator.

The MCO provides follow-up visits with the participant. The participant or their representative is required to report any changes that occur generating updates as needed to adjust services. The participant is involved in the development of the needs assessment regarding specific ADLs and IADLs associated with identified care needs and preferences.
MCO coordinates other federal and state program resources in the development of the POC.

As part of the transition to the KanCare comprehensive managed care program, Kansas has worked with CMS to identify and utilize some transition safeguards for people using HCBS waiver services. Those safeguards are detailed in the Special Terms and Conditions associated with the 1115 KanCare program, and are summarized here as follows:
a. For beneficiaries with no service assessment and revised service plan implemented within the first 180 days, the MCO will be required to continue the service plan already in existence for both service level and providers used until a new service plan is created, agreed upon by the enrollee, and implemented.
b. MCO to prioritize initial assessments and service planning to those individuals whose service plans expire within the first 90 or 180 days or whose needs change and necessitate a new service plan
c. Participant allowed to access all LTSS providers on their current service plan on a non-par basis for up to 180 days, 1 year for residential providers, or until a new service plan is agreed to and implemented (whichever is sooner). The new MCOs will make a priority to either get those providers in-network or focus on finding a new

provider of that service for the participant.
d. For the first 180 days of the KanCare program, State will review and approve all plans of care that have a reduction, suspension, or termination in services prior to the service plan being put in place. The enrollee will also have all appeal rights afforded through the MCO and state fair hearing process and the ability to continue services during the appeal.
e. State will complete "ride-alongs" with MCO case managers during the first 180 days to assess MCO compliance with service assessment and planning. State to report to CMS on the outcome of the ride-alongs.

Safeguards related to mitigating conflict of interest in the development of service plans:
Kansas retains the responsibility for both initial and annual eligibility determinations for all HCBS programs, which Kansas will conduct via contractors or providers with state oversight. Kansas has contracted with three managed care organizations, to provide overall management of these services as one part of the comprehensive KanCare program. The MCOs are responsible for plan of care development, and will be using their internal staff to provide that service. Kansas requires that conflict of interest be mitigated, and recognizes that the primary way in which that mitigation has been achieved is by separating from service providers the plan of care developmenting, and making that an MCO function. (In addition, conflict has been mitigated by Kansas separating the level of care determination from any service delivery or plan of care development.) Some of the additional safeguards that will be in place to ensure that there is no conflict of interest in this function include the following operational strategies for each MCO:
For Amerigroup:
- Care managers (CM) and Service Coordinators (SC) do not have access to financial data such as the rates the providers are paid
- CM and SCs cannot adjudicate or adjust claims
- Policies and procedures focus on POCs being member centered and providing choice among network providers
- Members get copies of the POC that provide the member the opportunity to identify mistakes and/or complain about CM/SC interaction
- Long-Term Services and Supports (LTSS) Members sign their assessment on IPAD
- Quality department monitors and trends complaints including those related to SCs
- Health Plan conducts CAHPS surveys that include opportunities for members to express their satisfaction with CM/SC
- Health Plan selects a sample of members per month, including those participating in LTSS, to send EOBs for services billed to conduct fraud surveillance and to drive complaints to the MCO as applicable if they are dissatisfied with their services
- MCO LTSS managers audits SC/CM to assure member driven service plans
- Members can appeal decisions related to a reduction of HCBS and any other services
- MCO will submit a report to the state, on a for information basis, of members for whom any reduction in the service plan was made and excluding services that are reduced to conform with benefit or program limits, because a consumer transitions out of a particular program HCBS program, loses eligibility, or other similar circumstance.
- MCO will allow existing POC to remain in place for 180 days or until the member is re-assessed, whichever comes first. Any reduction of a waiver service during that 180 day period must be reviewed and approved by the state.

For United Healthcare:
All operations, including but not limited to the clinical operations and functions of every UnitedHealthcare Community Plan are designed to ensure no conflict of interest with the Teams that are responsible for Plans of Care, service authorization, monitoring, payment and business management of the Health Plan. To this end, standard within the Kansas UnitedHealthcare Community Plan the following safeguards exist:

• The State of KS (not UnitedHealthcare Community Plan) retains the responsibility for member initial and annual eligibility determinations for waiver programs.
• UnitedHealthcare Community Plan has developed a network of contracted HCBS providers to deliver waiver services & does not directly employ any HCBS providers (including Financial Management Services providers for members who choose Consumer-Directed care).
• A member transitioning to UnitedHealthcare Community Plan effective January 1, 2013 will continue to receive services for up to 180 days according to the existing plan until a new assessment is completed by health plan care coordinators. During the initial 180 day transition period, reductions in waiver services will be reviewed/approved by the state.
• Service plans are developed based on member clinical and functional needs assessment (state approved), analysis of available informal supports, and standardized internal task/hour guidelines. Inter-rater reliability activities including joint member visits are conducted regularly by managers to assure consistency & accuracy of the assessment & service plan development process.

• HCBS provider selection is driven by member choice from the network, and if no member preference exists, referrals are made to network providers in the closest geographic proximity who are able to meet the member's preferred schedule.
• Prior authorizations are required for all HCBS services and submitted by the assigned care coordinator. A utilization management team separate from the care coordination team completes final reviews of the authorization to assure that the member is eligible for the requested waiver service and that the documentation supports the proposed service plan. Inter-rater reliability activities are also conducted regularly with the utilization management team.
• The Team that conducts care coordination and Plan of Care development is different from the Team that authorizes care and they have different reporting structures.
• All UnitedHealthcare health plans including the Kansas UnitedHealthcare Community Plan offer no compensation for any clinical staff that creates incentives for activities that would deny, limit, or discontinue medically necessary services to any member. Plan of Care development and service authorization decisions are based on appropriateness of care and existence of coverage.

For Centene/Sunflower: Conflict of Interest Safeguards

Safeguards
Sunflower State Health Plan's operations, including but not limited to the clinical operations and functions, are designed to ensure no conflict of interest exist between the teams that are responsible for Service Plans or Plan of Care, service authorization, monitoring, payment and business management of the Health Plan.

HCBS Providers Independence & Member Choice
Sunflower State Health Plan has developed a network of contracted HCBS providers to deliver waiver services and does not directly employ any HCBS providers (including Financial Management Services (FMS) providers for members who choose Consumer-Directed care).

Sunflower State works with the members to ensure member choice from our contracted network of providers. HCBS provider selection is driven by member choice from the network, and if no member preference exists, referrals are made to network providers in the closest geographic proximity who are able to meet the member's preferred schedule. The Case Manager will work closely with the member and our provider network to meet the member's service plan or plan of care.

A member transitioning to Sunflower State Health Plan effective January 1, 2013 will continue to receive services for 90 days according to the existing plan, or up to 180 days/until a new assessment is completed by health plan care coordinators (whichever occurs first). Please note that the State of Kansas retains responsibility for members' initial and annual eligibility determinations for waiver programs.

Service Plans
Service Plans are developed based on member clinical and functional assessment tools directed by the state, analysis of support system/community, utilization of members ADLs and IADL measurement, and leveling of care to determine and standardize tasking/hour guidelines for members' Service Plans. Case Management Managers and Director for Waiver programs, will conduct Case Management inter rater reliability ensuring consistency of case management's assessment and Service Plan development. This will be ongoing, reflecting improvement of and training or staff.

Prior authorizations are required for all HCBS services and submitted by the assigned care coordinator. The Medical Management team will meet to discuss HCBS service plan ensuring member's eligibility for the requested services. Review of the HRA assessment and additional measuring tools define and support service plan needs. Inter rater reliability activities and training continues ongoing. The Medical Management team consists of CM Manager, BH, Social Worker, RN Case Manager and Medical Director when appropriate regarding the development of care planning and services.

Service Plan development and service authorization decisions are based on appropriateness of care and existence of coverage. Sunflower's State Health Plan Care Manager team base service authorizations on appropriateness of care and benefit coverage with the development of the member's Service Plan.

Role Based Security

Sunflower State Health Plan has in place role-based security to ensure no conflict of interest between the Service Plan or Plan of Care development and claims payment. Role based access control (RBAC) allows Sunflower to

assign access to our Management Information Systems, in this case TruCare and Amisys Advance, to appropriately authorized personnel based on specific job roles. The claims processing team and clinical teams are two separate functional areas with different job roles and security. For Sunflower, the plans of care are developed in Kansas and the claims are processed in Great Falls, MT.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. **Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Risks are captured in the Functional Assessment Instrument (FAI). These risks include falls, behaviors, support systems, cognitive status, abuse, neglect, and exploitation. These issues are addressed in both the development of the Plan of Care (POC) and needs assessment. Identified risks are discussed with the participant and participant representatives. All participants are required to have a back-up plan for staffing requirements and emergency situations to mitigate the risk of not receiving services as outlined on the POC.
Participants are assessed on each risk, and service options are discussed and implemented, as needed, based on risk. Resources are available to meet participant needs for assistive equipment. State licensure requires that Home Health Agencies have back-up staff available to provide services and state regulations require that assisted living facilities, residential health care facilities, and homes plus have a written emergency management plan. If the participant chooses to self-direct, the participant is accountable for having staff available to meet their care needs

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. **Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

If the participant chooses to receive waiver services, the MCO provides a list of all service access agencies, including Financial Management Services (FMS), to the participant and assists with accessing information and supports from the participant's preferred qualified provider. These service access agencies have and make available to the participant the names and contact information of qualified providers of the waiver services identified in the POC.

The State assures that each participant found eligible for the waiver will be given free choice of all qualified providers of each service included in his/her written POC. The MCO presents each eligible participant a complete list of providers from which the participant can choose for self-directed services and a list of service providers for agency-directed services. The MCO assists the participant with assessing information and supports from the participant's preferred provider. These service access agencies have, and make available to the participant, the names and contact information of qualified providers of the waiver services identified in the participant's POC.

Participants have available access to an updated list of HCBS/PD waiver service access agencies at the Kansas Department for Aging and Disability Services/Community Services and Programs Commission (KDADS) web site. This list is also made available to participants at their annual reassessment and upon request.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. **Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i)

The consumer's chosen MCO and the consumer develop the consumer's Plan of Care from information gathered in the assessment. For the first 180 days of the transition to the KanCare program, any reduction in HCBS services on a consumer's plan of care must be reviewed and approved by the state. Further monitoring of services is conducted by the state consistent with the comprehensive KanCare quality improvement strategy. Included in that strategy is review of data that addresses:

- Access to services
- Freedom of choice
- Consumers needs met
- Safeguards in place to assure the health and welfare of the consumer are maintained
- Access to non-waiver services and informal supports
- Follow-up and remediation of identified programs

A critical component of that strategy is the engagement of the KanCare Interagency Monitoring Team, which will meet quarterly and bring together leadership, program management, contract management, fiscal management and other staff/resources of the SSMA and the Operating Agency to collectively monitor the extensive reporting, review results and other quality information and data related to the KanCare program and services.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. **Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. **Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☐ **Medicaid agency**
- ☐ **Operating agency**
- ☐ **Case manager**
- ☑ **Other**

Specify:

Service plans and related documentation will be maintained by the consumer's chosen KanCare MCO, and will be retained at least as long as this requirement specifies.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. **Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The three KanCare contracting managed care organizations are responsible for monitoring the implementation of the Plan of Care that was developed as a partnership between the consumer and the MCO and for ensuring the health and welfare of the consumer with input from the PD Program Manager, involvement of KDADS Regional Field Staff, and assessed with the comprehensive statewide KanCare quality improvement strategy (which includes all of the HCBS waiver performance measures).

On an ongoing basis, the MCOs monitor the Plan of Care and consumer needs to ensure:

- Services are delivered according to the Plan of Care;
- Consumers have access to the waiver services indicated on the Plan of Care;
- Consumers have free choice of providers and whether or not to self-direct their services;

- Services meet consumer's needs;
- Liabilities with self-direction/agency-direction are discussed, and back-up plans are effective;
- Consumer's health and safety are assured, to the extent possible; and
- Consumers have access to non-waiver services that include health services.

The Plan of Care is the fundamental tool by which the State will ensure the health and welfare of consumers served under this waiver. The KanCare MCOs, who deliver no direct waiver services to waiver participants, are responsible for both the initial and updated plans of care.

In-person monitoring by the MCOs is ongoing:
- Choice and monitoring are offered at least annually, regardless of current provider or self-direction, or at other life choice decision points, or any time at the request of the consumer.
- Choice is documented.
- The Plan of Care is modified to meet change in needs, eligibility, or preferences, or at least annually.

In addition, the Plan of Care and choice are monitored by state quality review and/or performance improvement staff as a component of waiver assurance and minimum standards. Issues found needful of resolution are reported to the MCO and waiver provider for prompt follow-up and remediation. Related information is reported to the PD Program Manager.

Service plan implementation and monitoring performance measures and related collection/reporting protocols, together with others that are part of the KanCare MCO contract, are included in a statewide comprehensive KanCare quality improvement strategy which is regularly reviewed and adjusted. That plan is contributed to and monitored through a state interagency monitoring team, which includes HCBS waiver program managers, fiscal staff and other relevant staff/resources from both the state Medicaid agency and the state operating agency.

State staff request, approve, and assure implementation of contractor/provider corrective action planning and/or technical assistance to address non-compliance with performance standards as detected through on-site monitoring, MCO compliance monitoring, survey results and other performance monitoring. These processes are monitored by both contract managers and other relevant state staff, depending upon the type of issue involved, and results tracked consistent with the statewide quality improvement strategy and the operating protocols of the Interagency Monitoring Team.

b. Monitoring Safeguards. *Select one:*

◉ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**

○ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of waiver participants whose service plans address their assessed needs and capabilities as indicated in the assessment N=Number of waiver participants whose service plans address their assessed needs and capabilities as indicated in the assessment D=Number of waiver participants whose service plans were reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☑ **Other** Specify: KanCare Managed Care Organizations (MCOs)	☐ **Annually**	☑ **Stratified** Describe Group: Proportionate by MCO
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of waiver participants whose service plans address participants' goals N=Number of waiver participants whose service plans address participants' goals D=Number of waiver participants whose service plans were reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☑ **Other** Specify: KanCare Managed Care Organizations (MCOs)	☐ **Annually**	☑ **Stratified** Describe Group: Proportionate by MCO
	☐ **Continuously and Ongoing**	☐ **Other**

		Specify:
	☐ Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☑ State Medicaid Agency	☐ Weekly
☑ Operating Agency	☐ Monthly
☐ Sub-State Entity	☑ Quarterly
☑ Other Specify: KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency	☑ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:
Number and percent of waiver participants whose service plans address health and safety risk factors N=Number of waiver participants whose service plans address health and safety risk factors D=Number of waiver participants whose service plans were reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☑ State Medicaid Agency	☐ Weekly	☐ 100% Review
☑ Operating Agency	☐ Monthly	☑ Less than 100% Review
☐ Sub-State Entity	☑ Quarterly	☑ Representative Sample

		Confidence Interval = 95%
☑ Other Specify: KanCare Managed Care Organizations (MCOs)	☐ Annually	☑ Stratified Describe Group: Proportionate by MCO
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify:	

Data Aggregation and Analysis:	
Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (e
sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the Stat
to analyze and assess progress toward the performance measure. In this section provide information
on the method by which each source of data is analyzed statistically/deductively or inductively, how

themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of waiver participants whose service plans were developed according to the processes in the approved waiver N = Number of waiver participants whose service plans were developed according to the processes in the approved waiver D = Number of waiver participants whose service plans were reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☑ **Other** Specify: KanCare Managed Care Organizations	☐ **Annually**	☑ **Stratified** Describe Group: Proportionate by MCO
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☐ Sub-State Entity	☑ Quarterly
☑ Other Specify: KanCare MCOs participate in the analysis of this measure's results as determined by the State operating agency	☑ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:
Number and percent of waiver participants (or their representatives) who were present and involved in the development of their service plan N=Number of waiver participants (or their representatives) who were present and involved in the development of their service plan D=Number of waiver participants whose service plans were reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☑ State Medicaid Agency	☐ Weekly	☐ 100% Review
☑ Operating Agency	☐ Monthly	☑ Less than 100% Review
☐ Sub-State Entity	☑ Quarterly	☑ Representative Sample Confidence Interval = 95%
☑ Other Specify: KanCare Managed Care Organizations (MCOs)	☐ Annually	☑ Stratified Describe Group: Proportionate by MCO
	☐ Continuously and Ongoing	☐ Other Specify:

☐ Other
Specify:

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☑ State Medicaid Agency	☐ Weekly
☑ Operating Agency	☐ Monthly
☐ Sub-State Entity	☑ Quarterly
☑ Other Specify: KanCare MCOs participate in the analysis of this measure's results as determined by the State operating agency	☑ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of service plans reviewed before the waiver participant's annual redetermination date N=Number of service plans reviewed before the waiver participant's annual redetermination date D=Number of waiver participants whose service plans were reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☑ State Medicaid Agency	☐ Weekly	☐ 100% Review
☑ Operating Agency	☐ Monthly	☑ Less than 100% Review
☐ Sub-State Entity	☑ Quarterly	☑ Representative Sample Confidence Interval = 95%
☑ Other Specify: KanCare Managed Care Organizations (MCOs)	☐ Annually	☑ Stratified Describe Group: Proportionate by MCO
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☑ State Medicaid Agency	☐ Weekly
☑ Operating Agency	☐ Monthly
☐ Sub-State Entity	☑ Quarterly
☑ Other Specify: KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency	☐ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*

Performance Measure:
Number and percent of waiver participants with documented change in needs whose service plan was revised, as needed, to address the change N=Number of waiver participants with documented change in needs whose service plan was revised, as needed, to address the change D=Number of waiver participants whose service plans were reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☑ State Medicaid Agency	☐ Weekly	☐ 100% Review
☑ Operating Agency	☐ Monthly	☑ Less than 100% Review
☐ Sub-State Entity	☑ Quarterly	☑ Representative Sample Confidence Interval = 95%
☑ Other Specify: KanCare Managed Care Organizations (MCOs)	☐ Annually	☑ Stratified Describe Group: Proportionate by MCO
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☑ State Medicaid Agency	☐ Weekly
☑ Operating Agency	☐ Monthly
☐ Sub-State Entity	☑ Quarterly
☑ Other Specify: KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency	☑ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of survey respondents who reported receiving all services as specified in their service plan N=Number of survey respondents who reported receiving all services as specified in their service plan D=Number of waiver participants interviewed by the QMS (Quality Management staff)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Customer interviews, on-site

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☑ State Medicaid Agency	☐ Weekly	☐ 100% Review
☑ Operating Agency	☐ Monthly	☑ Less than 100% Review
☐ Sub-State Entity	☑ Quarterly	

		☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☐ **Annually**	☑ **Stratified** Describe Group: Proportionate by MCO
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of waiver participants who received services in the type, scope, amount, duration, and frequency specified in the service plan N=Number of waiver participants who received services in the type, scope, amount, duration, and frequency specified in the service plan D=Number of waiver participants whose service plans were reviewed

Data Source (Select one):
Other

If 'Other' is selected, specify:

Record Reviews and Electronic Visit Verification (EVV) reports

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☑ State Medicaid Agency	☐ Weekly	☐ 100% Review
☑ Operating Agency	☐ Monthly	☑ Less than 100% Review
☐ Sub-State Entity	☑ Quarterly	☑ Representative Sample Confidence Interval = 95%
☑ Other Specify: KanCare Managed Care Organizations (MCOs)	☐ Annually	☑ Stratified Describe Group: Proportionate by MCO
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☑ State Medicaid Agency	☐ Weekly
☑ Operating Agency	☐ Monthly
☐ Sub-State Entity	☑ Quarterly
☑ Other Specify: KanCare MCOs participate in analysis of this measure's resulst as determined by the State operating agency	☑ Annually
	☐ Continuously and Ongoing
	☐ Other

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
	Specify:

e. ***Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of waiver participants whose record contains documentation indicating a choice of either self-directed or agency-directed care N = Number of waiver participants whose record contains documentation indicating a choice of either self-directed or agency-directed care D = Number of waiver participants whose files are reviewed for the documentation

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☑ State Medicaid Agency	☐ Weekly	☐ 100% Review
☑ Operating Agency	☐ Monthly	☑ Less than 100% Review
☐ Sub-State Entity	☑ Quarterly	☑ Representative Sample Confidence Interval = 95%
☑ Other Specify: KanCare Managed Care Organizations (MCOs)	☐ Annually	☑ Stratified Describe Group: Proportionate by MCO
	☐ Continuously and Ongoing	☐ Other

		Specify:
	☐ Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☑ State Medicaid Agency	☐ Weekly
☑ Operating Agency	☐ Monthly
☐ Sub-State Entity	☑ Quarterly
☑ Other Specify: KanCare MCOs participate in the analysis of this measure's results as determined by the State operating agency	☑ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:
Number and percent of waiver participants whose record contains documentation indicating a choice of waiver services N=Number of waiver participants whose record contains documentation indicating a choice of waiver services D=Number of waiver participants whose files are reviewed for the documentation

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☑ State Medicaid Agency	☐ Weekly	☐ 100% Review
☑ Operating Agency	☐ Monthly	☑ Less than 100% Review
☐ Sub-State Entity	☑ Quarterly	☑ Representative Sample

		Confidence Interval = 95
☑ **Other** Specify: KanCare Managed Care Organizations (MCOs)	☐ **Annually**	☑ **Stratified** Describe Group: Proportionate by MCO
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of waiver participants whose record contains documentation indicating a choice of community-based services v. an institutional alternative N = Number of waiver participants whose record contains documentation indicating a choice of community-based services D = Number fo waiver participants whose files are reviewed for the documentation

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☑ State Medicaid Agency	☐ Weekly	☐ 100% Review
☑ Operating Agency	☐ Monthly	☑ Less than 100% Review
☐ Sub-State Entity	☑ Quarterly	☑ Representative Sample Confidence Interval = 95%
☑ Other Specify: KanCare Managed Care Organizations (MCOs)	☐ Annually	☑ Stratified Describe Group: Proportionate by MCO
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☑ State Medicaid Agency	☐ Weekly
☑ Operating Agency	☐ Monthly
☐ Sub-State Entity	☑ Quarterly
☑ Other Specify: KanCare MCOs participate in the analysis of this measure's results as determined by the State operating agency	☑ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*

Performance Measure:
Number and percent of waiver participants whose record contains documentation indicating a choice of waiver service providers N=Number of waiver participants whose record contains documentation indicating a choice of waiver service providers D=Number of waiver participants whose files are reviewed for the documentation

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☑ State Medicaid Agency	☐ Weekly	☐ 100% Review
☑ Operating Agency	☐ Monthly	☑ Less than 100% Review
☐ Sub-State Entity	☑ Quarterly	☑ Representative Sample Confidence Interval = 95%
☑ Other Specify: KanCare Managed Care Organizations (MCOs)	☐ Annually	☑ Stratified Describe Group: Proportionate by MCO
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☑ State Medicaid Agency	☐ Weekly
☑ Operating Agency	☐ Monthly
☐ Sub-State Entity	☑ Quarterly
☑ Other Specify: KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency	☑ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Kansas Department of Health and Environment, Division of Health Care Finance (KDHE), the single state Medicaid agency, and Kansas Department for Aging and Disability Services (KDADS) work together to develop state operating agency priority identification regarding all waiver assurances and minimum standards/basic assurances. The state agencies work in partnership with consumers, advocacy organizations, provider groups and other interested stakeholders to monitor the state quality strategy and performance standards and discuss priorities for remediation and improvement. The state quality improvement strategy includes protocols to review cross-service system data to identify trends and opportunities for improvement related to all Kansas waivers, policy and procedure development and systems change initiatives.

Data gathered by KDADS Regional Staff during the Quality Survey Process, and data provided by the KanCare MCOs, is compiled quarterly for evaluation and trending to identify areas for improvement. Upon completion of identified areas of improvement this information is compiled into reports and shared both internally and externally, including with KDHE. As the KanCare program is operationalized, staff of the three plans will be engaged with state staff to ensure strong understanding of Kansas' waiver programs and the quality measures associated with each waiver program. Over time, the role of the MCOs in collecting and reporting data regarding the waiver performance measures will evolve, with increasing responsibility once the MCOs fully understand the Kansas programs. These measures and collection/reporting protocols, together with others that are part of the KanCare MCO contract, are included in a statewide comprehensive KanCare quality improvement strategy which is regularly reviewed and adjusted. That plan is contributed to and monitored through a state interagency monitoring team, which includes program managers, fiscal staff and other relevant staff/resources from both the state Medicaid agency and the state operating agency.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

State staff and/or KanCare MCO staff request, approve, and assure implementation of provider corrective action planning and/or technical assistance to address non-compliance with waiver and performance standards as detected through on-site monitoring, survey results and other performance monitoring. These processes are monitored by both program managers and other relevant state and MCO staff, depending upon the type of issue involved, and results tracked consistent with the statewide quality improvement strategy an the operating protocols of the Interagency Monitoring Team.

Monitoring and survey results are compiled, trended, reviewed, and disseminated consistent with protocols

identified in the statewide quality improvement strategy. Each provider receives annual data trending which identifies Provider specific performance levels related to statewide performance standards and statewide averages. Corrective Action Plan requests, technical assistance and/or follow-up to remediate negative trending are included in annual provider reports where negative trending is evidenced.

ii. **Remediation Data Aggregation**

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: KanCare Managed Care Organizations (MCOs)	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. **Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

◉ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

○ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one)*:

○ **Yes. The State requests that this waiver be considered for Independence Plus designation.**

◉ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

a) All consumers of PD waiver services have the opportunity to choose the KanCare managed care organization that will support them in overall service access and care management. The opportunity for participant direction (self direction) of Personal Services and Sleep Cycle Support services is made known to the consumer by the MCO, which is available to all waiver consumers (Kansas Statute 39-7,100).
This opportunity includes specific responsibilities required of the consumer, including:
- Recruitment and selection of Personal Care Attendants (PCAs), back-up PCAs and Sleep Cycle Support Service providers;
- Assignment of service provider hours within the limits of the authorized services;
- Complete an agreement with an enrolled Financial Management Services (FMS)provider;
- Referral of providers to the consumer's chosen FMS provider;
- Provider orientation and training;
- Maintenance of continuous service coverage in accordance with the Plan of Care, including assignment of replacement workers during vacation, sick leave, or other absences of the assigned attendant;
- Verification of hours worked and assurance that time worked is forwarded to the FMS provider;
- Other monitoring of services; and
- Dismissal of attendants, if necessary.

b) Consumers are provided with information about self direction of services and the associated responsibilities by the MCO during the service planning process. Once the consumer is deemed eligible for waiver services, the option to self-direct is offered and, if accepted, the choice is indicated on a Consumer Choice form and included in the consumer's Plan of Care.

The MCO assists the consumer with identifying an FMS provider and related information is included in the consumer's Plan of Care. The MCO supports the consumer who selects self direction of services by monitoring services to ensure that they are provided by Personal Care Attendants and Sleep Cycle Support attendants in accordance with the Plan of Care and the Attendant Care Worksheet, which are developed by the consumer with assistance from the MCO. The MCO also provides the same supports given to all waiver consumers, including Plan of Care updates, referral to needed supports and services, and monitoring and follow-up activities.

c) The Financial Management Services provider offers supports to the consumer as described in Appendix C.

d) For all health maintenance activities, the consumer shall obtain a completed Physician/RN Statement to be signed by an attending physician or registered professional nurse. The statement must identify the specific activities that have been authorized by the physician or registered professional nurse. The MCO is responsible to ensure that the Physician/RN Statement is completed in its entirety.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waive
Select one:

◉ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available participants who exercise this authority.

○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.

○ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in *Appendix E-2*. Supports and protections are available for participants who exercise these authorities.

c. **Availability of Participant Direction by Type of Living Arrangement.** *Check each that applies:*

☑ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**

☐ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**

☐ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. **Election of Participant Direction.** Election of participant direction is subject to the following policy *(select one):*

○ **Waiver is designed to support only individuals who want to direct their services.**

◎ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**

○ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. **Information Furnished to Participant.** Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

a) Consumers are informed that, when choosing participant direction (self direction) of services, they must exercise responsibility for making choices about attendant care services, understand the impact of the choices made, and assume responsibility for the results of any decisions and choices they make. Consumers are provided with, at a minimum, the following information about the option to self direct services:
- the limitation to Personal Services and Sleep Cycle Support services;
- the need to select and enter into an agreement with an enrolled Financial Management Services (FMS) provider;
- related responsibilities (outlined in E-1-a);
- potential liabilities related to the non-fulfillment of responsibilities in self-direction;
- supports provided by the managed care organization (MCO) they have selected;
- the requirements of personal care attendants;
- the ability of the consumer to choose not to self direct services at any time; and

• other situations when the MCO may discontinue the consumer's participation in the self-direct option and recommend agency-directed services.

b) The MCO is responsible for sharing information with the consumer about self direction of services by the consumer. The FMS provider is responsible for sharing more detailed information with the consumer about self-direction of services once the consumer has chose this option and identified an enrolled provider. This information is also available from the PD Program Manager, KDADS Regional Field Staff, and is also available through the online version of the HCBS PD Waiver Policies and Procedures Manual.

c) Information regarding self-directed services is initially provided by the MCO during the plan of care/service plan process, at which time the Consumer Choice form is completed and signed by the consumer, and the choice is indicated on the consumer's Plan of Care. This information is reviewed at least annually with the member. The option to end self direction can be discussed, and the decision to choose agency-directed services can be made at any time.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the State's policy concerning the direction of waiver services by a representative *(select one):*

○ **The State does not provide for the direction of waiver services by a representative.**

◉ **The State provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

☑ **Waiver services may be directed by a legal representative of the participant.**

☑ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Waiver services may be directed by a non-legal representative of an adult waiver-eligible consumer. An individual acting on behalf of the consumer must be freely chosen by the consumer. This includes situations when the representative has an activated durable power of attorney (DPA). The DPA process involves a written document in which consumers authorize another individual to make decisions for them in the event that they cannot speak for themselves. A DPA is usually activated for health care decisions. The extent of the non-legal representative's decision-making authority can include any or all of the responsibilities outlined in E-1-a that would fall to the consumer if he/she chose to self-direct services. Typically a durable power of attorney for health care decisions, if activated, cannot be the consumer's paid attendant for Personal Services and/or Sleep Cycle Support.

Safeguards include:
• If the designation of the appointed representative is withdrawn, the individual may become the consumer's paid attendant for Personal Services and/or Sleep Cycle Support after the next annual review or a significant change in the consumer's needs occurs prompting a reassessment.

• When an individual acting on behalf of the consumer is the holder of the consumer's durable power of attorney for health care decisions, and is also the attendant for PD waiver services under the "grandfathered" standard, the MCO chosen by the consumer must complete a monitoring visit at least every three months to ensure the selected caregiver is performing the necessary tasks as outlined in the consumer's Plan of Care (POC). As of January 1, 2000, the HCBS/PD waiver, as approved by CMS, states that "persons directing a consumer's care through the self-directed care option may not be a provider of this service." Those providing the service prior to this date have been "grandfathered" under this standard.

• A consumer who has been adjudicated as needing a guardian and/or conservator cannot choose care. The consumer's guardian and/or consevator may choose to self-direct the consumer's care. An adult PD waiver consumer's legal guardian and/or conservator cannot, however, act as the consumer's paid attendant for

Personal Services and/or Sleep Cycle Support.

To ensure that non-legal representatives function in the best interests of the consumer, additional safeguards are in place. Quality of care is continuously monitored by the MCO. The MCO may discontinue the self direct option and offer agency-directed services when, in the judgment of the MCO, as observed and documented in the consumer's case file, certain situations arise, particularly when the consumer's health and welfare needs are not being met. In addition, post-pay reviews completed by the fiscal agent and quality assurance reviews completed by the KDADS Regional Field Staff and/or MCO staff serve to monitor consumer services, and serve as safeguards to ensure the consumer's best interests are followed.

Any decision to restrict or remove a participant's opportunity to self-direct care, made by a KanCare MCO, is subject to the grievance and appeal protections detailed in Appendix F.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. **Participant-Directed Services.** Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Participant-Directed Waiver Service	Employer Authority	Budget Authority
Personal Care Services	☑	☐
Sleep Cycle Support	☑	☐

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. **Financial Management Services.** Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**

☑ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. **Provision of Financial Management Services.** Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

◉ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:
Financial Management Services

○ **FMS are provided as an administrative activity.**

Provide the following information

i. **Types of Entities:** Specify the types of entities that furnish FMS and the method of procuring these services:

Enrolled FMS providers will furnish Financial Management Services using the Agency with Choice provider model. The provider requirements will be published and placed on the Kansas Medical Assistance Program (KMAP) website and/or in the KanCare MCO provider manuals and websites.
Organizations interested in providing Financial Management Services (FMS) are required to submit a signed Provider Agreement to the State Operating Agency, KDADS, prior to enrollment to provide the service. The agreement identifies the waiver programs under which the organization is requesting to provide FMS and outlines general expectations and specific provider requirements. In addition, organizations are required to submit the following documents with the signed agreement:

- Community Developmental Disability Organization (CDDO) agreement (DD only)
- Secretary of State Certificate of Corporate Good Standing
- W-9 form
- Proof of Liability Insurance
- Proof of Workers Compensation insurance
- Copy of the most recent quarterly operations report or estimate for first quarter operations
- Financial statements (last 3 months bank statements or documentation of line of credit)
- Copy of the organization's Policies and Procedures manual, to include information that covers requirements listed in the FMS Medicaid Provider Manual.

The FMS provider agreement and accompanying documentation are reviewed by the State Operating Agency and all assurances are satisfied prior to signing by the Secretary of KDADS (or designee). KanCare MCOs should not credential any application without evidence of a fully executed FMS Provider agreement.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

FMS providers will be reimbursed a monthly fee per consumer through the electronic Plans of Care system (MMIS). The per member per month payment was estimated based upon a formula that included all direct and indirect costs to payroll agents and an average hourly rate for direct care workers. Information was gathered as part of a Systems Transformation Grant study conducted by Myers & Stauffer. Under the KanCare program, FMS providers will contract with MCOs for final payment rates, which cannot be less than the current FFS rate.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

- [x] **Assist participant in verifying support worker citizenship status**
- [x] **Collect and process timesheets of support workers**
- [x] **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- [ ] **Other**

Specify:

Supports furnished when the participant exercises budget authority:

- [ ] **Maintain a separate account for each participant's participant-directed budget**
- [ ] **Track and report participant funds, disbursements and the balance of participant funds**
- [ ] **Process and pay invoices for goods and services approved in the service plan**
- [ ] **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other services and supports**

Specify:

Additional functions/activities:

- ☐ **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- ☐ **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- ☐ **Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget**
- ☐ **Other**

Specify:

iv. **Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

(a) The state verifies FMS providers meet waiver standards and state requirements to provide financial management services through a biennial review process. A standardized tool is utilized during the review process and the process includes assurance of provider requirements, developed with stakeholders and the State Medicaid Agency (Kansas Department of Health and Environment [KDHE]). Requirements include agreements between the FMS provider and the participant, Direct Support Worker and the State Medicaid Agency and verification of processes to ensure the submission of Direct Support Worker time worked and payroll distribution. Additionally, the state will assure FMS provider development and implementation of procedures including, but not limited to, procedures to maintain background checks; maintain internal quality assurance programs to monitor participant and Direct Support Worker satisfaction; maintain a grievance process for Direct Support Workers; and offer choice of Information and Assistance services.

The Division of Legislative Post Audit contracts with an independent accounting firm to complete Kansas' state wide single audit each year. The accounting firm must comply with all requirements contained in the single audit act. The Medicaid program, including all home and community based services waivers, is a required component of every single state audit. Independent audits of the waiver will look at cost-effectiveness, the quality of services, service access, and the substantiation of claims for HCBS payments. Each HCBS provider is to permit KDHE or KDADS, their designee, or any other governmental agency acting in its official capacity to examine any records and documents that are necessary to ascertain information pertinent to the determination of the proper amount of a payment due from the Medicaid program. The Surveillance and Utilization Review Unit of the fiscal agent completes the audits of both participants and providers (K.A.R. 30-5-59).

(b) The Operating Agency is responsible for performing and monitoring the FMS review process. State staff will conduct the review and the results will be monitored by KDADS. A system for data collection, trending and remediation will be implemented to address individual provider issues and identify opportunities for systems change. KDHE through the fiscal agent maintains financial integrity by way of provider agreements signed by prospective providers during the enrollment process and contract monitoring activities.

(c) All FMS providers are assessed on a biennial basis through the FMS review process and as deemed necessary by the State Medicaid Agency.

(d) State staff will share the results of state monitoring and auditing requirements, with the KanCare MCOs, and state/MCO staff will work together to address/remediate any issue identified. FMS providers also must contract with KanCare MCOs to support KanCare members, and will be included in monitoring and reporting requirements in the comprehensive KanCare quality improvement strategy.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☐ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

☑ **Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Financial Management Services	☑
Home-Delivered Meals Service	☐
Medication Reminder Services	☐
Personal Emergency Response System and Installation	☐
Personal Care Services	☐
Assistive Services	☐
Sleep Cycle Support	☐

☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

○ **No. Arrangements have not been made for independent advocacy.**

◉ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Independent advocacy is available to consumers, on a consumer-specific basis, who direct their services through a number of community organizations and through the Disability Rights Center of Kansas (DRC), the

state's Protection and Advocacy organization. These organizations do not provide direct services either through the waiver or through the Medicaid State Plan.

The Disability Rights Center of Kansas is a public interest legal advocacy agency empowered by federal law to advocate for the civil and legal rights of Kansans with disabilities. DRC operates eight federally authorized and funded protection and advocacy programs in Kansas. Consumers are referred directly to DRC from various sources including KDADS.

Various community and disability organizations such as the Cerebral Palsy Research Foundation offer independent advocacy for Kansas consumers.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. **Voluntary Termination of Participant Direction.** Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

One of the consumer's opportunities, as well as responsibilities, is the ability to discontinue the self-direct option. At any time, if the consumer chooses to discontinue the self-direct option, he/she is to:

- Notify all providers as well as the Financial Management Services (FMS) provider.
- Maintain continuous attendant coverage for authorized Personal Services and/or Sleep Cycle Support.
- Give ten (10) day notice of his/her decision to the KanCare MCO chosen by the consumer, to allow for the coordination of service provision.

The duties of the consumer's KanCare MCO are to:

- Explore other service options and complete a new Consumer Choice form with the consumer; and
- Advocate for consumers by arranging for services with individuals, businesses, and agencies for the best available service within limited resources.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. **Involuntary Termination of Participant Direction.** Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

The participant's chosen KanCare MCO or the KDADS may discontinue the participant's participation in the self-directed option and offer agency-directed services when, in the MCO's professional judgment as observed and documented in the participant's case file, one or more of the following occurs:

1. if the participant/representative does not fulfill the responsibilities and functions required;
2. if the health and welfare needs of the participant are not met as observed by the MCO or confirmed by the Kansas Department of Children and Families (DCF) Adult Protective Services (APS);
3. if the direct support worker has not adequately performed the services as outlined on the needs assessment);
4. if the direct support worker has not adequately performed the necessary tasks and procedures; or
5. if the participant/representative or SERVICE PROVIDERS has abused or misused the self-directed care option, such as, but not limited to:

• the participant/representative has directed the direct support worker to provide, and the direct support worker has in fact provided paid attendant care services beyond the scope of the needs assessment and/or POC;
• the participant/representative has directed the SERVICE PROVIDERS to provide, and the SERVICE PROVIDERS has in fact provided paid comprehensive support or sleep cycle support beyond the scope of the service definition;
• the participant/representative has submitted signed time sheets for services beyond the scope of the needs assessment and/or the POC;
• the participant/representative has continually directed the direct support worker to provide care and services beyond the limitations of their training, or the training of the SERVICE PROVIDERS for health maintenance

activities in a manner that has a continuing adverse effect on the health and welfare of the participant.
The following warrant termination of the self-directed care option without the requirement to document an attempt to remedy:
1. the participant/representative has falsified records that result in claims for services not rendered;
2. the participant has Health Maintenance Activities or medication setup and the participants attending physician or RN no longer authorizes the participant to self-direct his/her care; or
3. the participant/representative has committed a fraudulent act.

A timely Notice of Action (NOA) shall be sent to the participant prior to the effective date for termination of the participant's participation in the Self-Directed Care Option. The MCO coordinates to ensure there is not a lapse in service delivery.

The MCO works with the participant to maintain continuous attendant coverage as outlined and authorized on the participant's POC. The MCO, though their care management and monitoring activities, works with the participant's choice of a non-self-directed agency to assure participant health and welfare during the transition period and beyond by communicating with both the participant and the non-self-directed agency, by monitoring the services provided, and by gathering continual input from the participant as to satisfaction with services.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. **Goals for Participant Direction.** In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 1	7278	
Year 2	6863	
Year 3	6472	
Year 4	6472	
Year 5	6472	

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. **Participant - Employer Authority** *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. **Participant Employer Status.** Specify the participant's employer status under the waiver. *Select one or both:*

☑ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

Consumers execute an agreement with enrolled providers of Financial Management Services (FMS) to act as co-employers of workers who provide participant-directed waiver services. FMS providers are those agencies that have completed and maintain in good standing a provider agreement with the State

operating agency, a Medicaid provider agreement with the State Medicaid agency through the State's fiscal agent, and a contract with the consumer's KanCare MCO.

FMS provider agencies perform necessary payroll and human resource functions and provide to the participant the supports necessary to conduct employer-related functions, including the selection and training of individuals who will provide the needed assistance and the submission of complete and accurate time records to the FMS provider agency.

☐ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. **Participant Decision Making Authority.** The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☑ **Recruit staff**
☑ **Refer staff to agency for hiring (co-employer)**
☐ **Select staff from worker registry**
☐ **Hire staff common law employer**
☑ **Verify staff qualifications**
☑ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

The FMS provider covers the cost of the criminal history and/or background investigation of staff should the consumer request one.

☑ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
☑ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
☐ **Determine staff wages and benefits subject to State limits**
☑ **Schedule staff**
☑ **Orient and instruct staff in duties**
☑ **Supervise staff**
☑ **Evaluate staff performance**
☑ **Verify time worked by staff and approve time sheets**
☐ **Discharge staff (common law employer)**
☑ **Discharge staff from providing services (co-employer)**
☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. **Participant - Budget Authority** *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

i. **Participant Decision Making Authority.** When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- ☐ **Reallocate funds among services included in the budget**
- ☐ **Determine the amount paid for services within the State's established limits**
- ☐ **Substitute service providers**
- ☐ **Schedule the provision of services**
- ☐ **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- ☐ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- ☐ **Identify service providers and refer for provider enrollment**
- ☐ **Authorize payment for waiver goods and services**
- ☐ **Review and approve provider invoices for services rendered**
- ☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

ii. **Participant-Directed Budget** Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iii. **Informing Participant of Budget Amount.** Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iv. **Participant Exercise of Budget Flexibility.** *Select one*:

- **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. **Participant - Budget Authority**

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

v. **Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice (s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Kansas has contracted with an ADRC to conduct level of care determinations. Decisions made by the ADRC are subject to state fair hearing review, and notice of that right and related process will be provided by the ADRC with their decision on the LOC determination/redetermination.

Kansas has contracted with three KanCare managed care organizations (MCOs) who are required to have grievance and appeal processes that meet all relevant federal and state standards, including state fair hearings and expedited appeals. Each MCO has established operational processes regarding these issues, about which they must inform every member. In addition, the State will review member grievances/appeals during the initial implementation of the KanCare program on a daily basis to see if there are issues with getting into care, ability to get prescriptions or ability to reach a live person on the phone. The State will report to CMS the number and frequency of these types of complaints/grievances during the initial transition period, and will continue to monitor this issue throughout the KanCare program.

Each member is provided information about grievances, appeals and fair hearings in their KanCare member enrollment packet. A grievance is any expression of dissatisfaction about any matter other than an Action. Grievances can be filed in

writing or verbally. Grievances will be acknowledged by MCOs in writing within 10 business days of receipt, and a written response to the grievance will be given to the member within 30 business days (except in cases where it is in the best interest of the member that the resolution timeframe be extended). In addition to filing grievances, KanCare members have the right to submit a request for a fair hearing.

All KanCare members are advised the following regarding appeals and state fair hearings:

An appeal can only occur under the following circumstances:
• If an Action has occurred. An Action is the denial of services or a limitation of services, including the type of service; the reduction, suspension, or termination of a service you have been receiving; the denial, in whole or part, of payment for a service; or the failure of the health plan to act within established time requirements for service accessibility.
• You will receive a Notice of Action in the mail if an Action has occurred.
• An Appeal is a request for a review of any of the above actions.
• To file an Appeal: You, your friend, your attorney, or anyone else on your behalf can file an appeal.
• An appeal can be filed verbally, but it must be followed by a written request. The Customer Service Center for your health plan can also help you with an appeal.
• An appeal must be filed within 30 calendar days after you have received a Notice of Action.
• The appeal will be resolved within 30 calendar days unless more time is needed. You will be notified of the delay, but your appeal will be resolved in 45 calendar days.

You have other options for a quicker review of your appeal. Call your health plan for more information.

Fair Hearings
A Fair Hearing is a formal meeting where an impartial person (someone you do not know), assigned by the Office of Administrative Hearings, listens to all of the facts and then makes a decision based on the law.
• If you are not satisfied with the decision made on your appeal, you or your representative may ask for a fair hearing. It must be done in writing and mailed or faxed to:

Office of Administrative Hearings
1020 S. Kansas Ave.
Topeka, KS 66612-1327
Fax: 785-296-4848
• The letter or fax must be received within 30 days of the date of the appeal decision.

Members have the right to benefits while a hearing is pending, and can request such benefits as part of their fair hearing request. All three MCOs will advise members of their right to a State Fair Hearing. Members do not have to finish their appeal with the MCO before requesting a State Fair Hearing.

Addressing specific additional elements required by CMS:

I. How individuals are informed of the Fair Hearing process during entrance to the waiver including how, when and by whom this information is provided to individuals.
For all KanCare MCOs: In addition to the education provided by the State, members receive information about the Fair Hearing process in the member handbook they receive at the time of enrollment. The member handbook is included in the welcome packet provided to each member. It will also be posted online at the MCOs' member web site. In addition, every notice of action includes detailed information about the Fair Hearing process, including timeframes, instructions on how to file, and who to contact for assistance. And, at any time a member can call the MCO to get information and assistance with the Fair Hearing process.

II. All instances when a notice must be made to an individual of an adverse action including: 1) choice of HCBS vs. institutional services, 2) choice of provider or service, and 3) denial, reduction, suspension or termination of service.

The state requires that all MCOs define an "action" pursuant to KanCare RFP Attachment C and 42 CFR §438.400. While the State determines, including through contracting entities, eligibility for HCBS waivers and is responsible for notifying an individual of an adverse action in the event that their application (choice of HCBS vs. institutional services) is denied, MCOs issue a notice of adverse action under the following circumstances:
• The denial or limited authorization of a requested service, including the type or level of service;
• The reduction, suspension, or termination of a previously authorized service;
• The denial, in whole or in part, of payment for a service;
• The failure to provide services in a timely manner;

• The failure of an Amerigroup to act within the timeframes provided in 42 CFR §438.408(b); and
• For a resident of a rural area with only one MCO, the denial of a Medicaid enrollee's request to exercise his or her right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the network.

III. How notice of adverse action is made.
Amerigroup: Once the decision to deny a service is made, the Medical Director notifies the Health Care Management Services department of the denial by routing the authorization request to specified queues within Amerigroup's system of record (Facets). An Amerigroup Utilization Management nurse reviews the denial, makes any necessary updates to the authorization and routes it to the designated denial queue in Facets. The Case Specialist assigned to the queue will create the letter in Amerigroup's document repository system (Macess) under the member's account and send to the Amerigroup Document Control Center (DCC) for mailing to both the member and the provider.
Sunflower: Sunflower will issue notice of adverse actions in writing. The notice of action letters utilized by Sunflower will have the prior written approval of KDHE before they are used. Written notification of adverse action may also be supplemented with telephonic and/or face-to-face notifications if necessary.
United: A Notice of Action is provided in writing to the member with a cc: to the provider.

IV. The entity responsible for issuing the notice
Amerigroup: Case Specialists in the Amerigroup Health Care Management Services Department are responsible for issuance of the notice (which includes the Amerigroup Medical Director's signature). These notices are sent from the Case Specialist to Amerigroup's Document Control Center for mailing.
Sunflower: Sunflower State Health Plan is responsible for issuing notifications to its enrolled members. Subcontracted entities who may be delegated appeal may also issue Notice of Action letters to members who are denied or received reduction of services that the delegated entity provides. All of the Sunflower's subcontracted entities will use the previously approved notice of action and grievance/appeal process letters that Sunflower uses.
United: UnitedHealthcare Community Plan will be issuing the notices.

V. The assistance (if any) that is provided to individuals in pursuing a Fair Hearing.
Amerigroup: The Amerigroup Quality Management Department includes Member Advocates that are dedicated to tasks such as helping members file grievances, appeals and Fair Hearings. If a member calls the Amerigroup Member Services line to request assistance with a Fair Hearing, our call center provides a transfer to the Member Advocate who assists the member.
Sunflower: Sunflower's Member Service Representative, Grievance and Appeals Coordinators and Care Managers will all be available to provide personal assistance to members needing support at any stage of the grievance process including Fair Hearing. They will provide information to members about their rights, how access the Fair Hearing process, provide assistance in completing any required documentation and provide all information relevant to the issue giving rise to the need for a Fair Hearing. In addition, Members will have access to communication assistance such as translation, TTY/TTD availability, interpreter services or alternative formats for member materials.
United: UnitedHealthcare has Member Advocates who can provide general assistance and a Plan Grievance Coordinator who is available to assist members with filing the request and who will prepare the files for submission to the State.

VI. Specify where notices of adverse action and the opportunity to request a Fair Hearing are kept.
Amerigroup: Template Notice of Adverse Action letters are housed in Amerigroup's electronic document repository system (Macess). When individual letters are created, they are saved in the member's individual folder within this system. All these letters include notification of the opportunity to request a Fair Hearing.
Sunflower: Sunflower will maintain records of all notices of adverse action letters issued to members, with the required Fair Hear rights and process language, in our TruCare Medical Management application and in our Customer Relations Management (CRM) application used to track and report events in the grievance process.
United: Notice of Action letters are maintained in corporate letter archives. They are tied to the notification number in our CareOne Medical Management System. They are indexed by State, date of notice, member name. product (i.e. Medicaid) and notification number.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. **Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

◉ **No. This Appendix does not apply**
○ **Yes. The State operates an additional dispute resolution process**

b. **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. **Operation of Grievance/Complaint System.** *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. **Operational Responsibility.** Specify the State agency that is responsible for the operation of the grievance/complaint system:

Under the KanCare program, nearly all Medicaid services - including nearly all HCBS waiver services - will be provided through one of the three contracting managed care organizations. However, for those situations in which the participant is not a KanCare member, this grievance/complaint system applies. The Single State Medicaid Agency, Kansas Department of Health and Environment (KDHE), employs the fiscal agent to operate the consumer complaint and grievance system. (A description as to how KanCare members are informed that filing a grievance is not a prerequisite for a Fair Hearing is inluded at Appendix F.1.)

c. **Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Medical Assistance Customer Service Center (MACSC) at the fiscal agent is open to any complaint, concern, or grievance a consumer has against a Medicaid provider. The Consumer Assistance Unit staff logs and tracks all complaints, concerns, or grievances. If a provider has three complaints lodged against them, an investigation is initiated. KDHE and KDADS have access to this information at any time.

The MACSC transfers grievances to the Quality Assurance Team (QAT) on the date received. QAT has three (3) days to contact the grievant to acknowledge the grievance and thirty (30) days to coomplete the research and resolution. If more time is needed, QAT must request additional time from the state Program Manager.

QAT trends grievances on a monthly basis. Criterion for further research is based on number of grievances per provider in a specific time frame.

Consumers who are not part of the KanCare program are educated that lodging a complaint and/or grievance is not a pre-requisite or substitute for a Fair Hearing and is a separate activity from a Fair Hearing. This information may also be provided by the PD Waiver Program Manager.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. **Critical Event or Incident Reporting and Management Process.** Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program.*Select one:*

- ◉ **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ○ **No. This Appendix does not apply** *(do not complete Items b through e)*

If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

b. **State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The state provides for the reporting and investigation of the following major and serious incidents.

• Definitions of the types of critical events or incidents that must be reported:

Abuse: Any act or failure to act performed intentionally or recklessly that causes or is likely to cause harm to an adult including: 1) infliction of physical or mental injury; 2) any sexual act with an adult when the adult does not consent or when the other person knows or should know that the adult is incapable or resisting or declining consent to the sexual act due to mental deficiency or disease or due to fear of retribution or hardship; 3) unreasonable use of a physical restraint, isolation or medication that harms or is likely to ham an adult; 4)unreasonable use of a physical or chemical restraint, medication or isolation as punishment for convenience, in conflict with a physician's orders or as a substitute for treatment, except where such conduct or physical restraint is in furtherance of the health and safety of the adult; 5)a threat or menacing conduct directed toward an adult that results or might reasonably be expected to result in fear or emotional or mental distress to an adult; 6)fiduciary abuse; or 7)omission or deprivation by a caretaker or another person of goods or services which are necessary to avoid physical or mental harm or illness. K.S.A 39-1430(b).

Neglect: The failure or omission by one's self, caretaker or another person with a duty to supply or to provide goods or services which are reasonably necessary to ensure safety and well-being and to avoid physical or mental harm or illness. K.S.A 39-1430(c).

Exploitation: Misappropriation of an adult's property or intentionally taking unfair advantage of an adult's physical or financial resources for another individual's personal financial advantage by the use of undue influence, coercion, harassment, duress, deception, false representation or false pretense by a caretaker or another person. K.S.A. 39-1430(d).

Fiduciary Abuse: A situation in which any person who is the caretaker of, or who stands in a position of trust to, an adult, takes, secretes, or appropriates his/her money or property, to any use of purpose not in the due and lawful execution of such person's trust or benefit. K.S.A 39-1430(e).

• Identification of the individuals/entities that must report critical events and incidents:

The Kansas statute (K.S.A. 39-1431) identifies mandated reporters required to report suspected abuse neglect, and exploitation or fiduciary abuse immediately to either Social and Rehabilitation Services (now the Kansas Department for Children and Families) or Law Enforcement. According to K.S.A. 39-1431, mandated reporters include: (a) Any person who is licensed to practice any branch of the healing arts, a licensed psychologist, a licensed master level psychologist, a licensed clinical psychotherapist, the chief administrative officer of a medical care facility, a teacher, a licensed social worker, a licensed professional nurse, a licensed practical nurse, a licensed dentist, a licensed marriage and family therapist, a licensed clinical marriage and family therapist, licensed professional counselor, licensed clinical professional counselor, registered alcohol and drug abuse counselor, a law enforcement officer, a case manager, a rehabilitation counselor, a bank trust officer or any other officers of financial institutions, a legal representative, a governmental assistance provider, an owner or operator of a residential care facility, an independent living counselor and the chief administrative officer of a licensed home health agency, the chief administrative officer of an adult family home and the chief administrative officer of a provider of community services and affiliates thereof operated or funded by the department of social and rehabilitation services [now the Kansas Department for Children and Families] or licensed under K.S.A. 75-3307b and amendments thereto who has reasonable cause to believe that an adult is being or has been abused, neglected or exploited or is in need of protective services shall report, immediately from receipt of the information, such information or cause a report of such information to be made in any reasonable manner. An employee of a domestic violence center shall not be

required to report information or cause a report of information to be made under this subsection.

• The timeframes within which critical events or incidents must be reported:

All reports of abuse, neglect, and exploitation must be reported to the Kansas Department for Children and Families immediately.

• The method of reporting:

Reports shall be made to the Kansas Department for Children and Families, by calling the Kansas Protection Report Center (a section of DCF), via their 24/7 in-state toll free number: 1-800-922-5330. Telephone lines are staffed in the report center 24 hours a day, including holidays. In the event of an emergency, a report can be made to local law enforcement or 911.

c. **Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

The participant's chosen KanCare MCO provides information and resources to all consumers and caregivers regarding strategies to identify, prevent, report, and correct any instances of potential Abuse, Neglect or Exploitation. Information and training on these subjects is provided by the MCOs to members in the member handbook, is available for review at any time on the MCO member website, and is reviewed with each member, by the care management staff responsible for service plan development, during the annual process of plan of care/service plan development. Depending upon the individual needs of each member, additional training or information is made available and related needs are addressed in the individual's service plan. The information provided by the MCOs is consistent with the state's abuse, neglect and exploitation incident reporting and management process (although the MCOs also have additional incident management information and processes beyond those regarding reporting/management of member abuse, neglect and exploitation).

d. **Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

• The entity that receives reports of each type of critical event or incident: Kansas Department for Children and Families.

• The entity that is responsible for evaluating reports and how reports are evaluated.
Kansas Department for Children and Families (DCF) Intake Unit is responsible for receiving reports and determining if each report is screened in or out based on current policies identified in The Kansas Economic and Employment Support Manual [KEESM] for screening reports [12210]. If the report indicates criminal activity, local law enforcement is notified immediately.

• The timeframes for conducting an investigation and completing an investigation.
For children, the State of Kansas requires reporting of any suspected Abuse, Neglect, Exploitation or Fiduciary Abuse of a child to DCF for review and follow-up. If the report alleges that a child is not in immediate, serious, physical danger, but the report alleges critical neglect or physical/sexual abuse, DCF must respond within 72 hours. If the report alleges that a child is not in immediate, serious, physical danger and the report does not allege physical or sexual abuse or neglect, DCF must respond within 20 working days. By policy, Children and Family Services (CFS) is required to make a case finding in 25 working days from case assignment.

For adults, the State of Kansas requires reporting of any suspected Abuse, Neglect, Exploitation or Fiduciary Abuse of an adult to DCF for review and follow-up. K.S.A. 39-1433 establishes time frames for personal visits with involved adults and due dates for findings for DCF investigations. This statute identifies the following:
1. Twenty-four (24) clock hours if the involved adult's health or welfare is in imminent danger.
2. Three (3) working days if the involved adult has been abused but is not in imminent danger.
3. Five (5) working days if the adult has been neglected or exploited and there is no imminent danger.

• The entity that is responsible for conducting investigations and how investigations are conducted.
Kansas Department for Children and Families is responsible for contacting the involved adult, alleged perpetrator and all other collaterals to obtain relevant information for investigation purposes.

1. Interview the involved adult. If the involved adult has a legal guardian or conservator, contact the guardian and/or conservator.
2. Assess the risk of the involved adult.
3. The APS social worker should attempt to obtain a written release from involved adult or their guardian to receive/review relevant records maintained by others.

• The process and timeframes for informing the participant including the participant (or the participant's family or legal representative as appropriate) and other relevant parties (e.g., the waiver providers, licensing and regulatory authorities, the waiver operating agency) of the investigation results.
2540 Notice of Department Finding:

The Notice of Department Finding for family reports is CFS 2012. The Notice of Department Finding for facility reports is CFS 2013. The Notice of Department Finding informs pertinent persons who have a need to know of the outcome of an investigation of child abuse/neglect. The Notice of Department Finding also provides persons information regarding the appeal process. The following persons must receive a notice:
• The parents of the child who was alleged to have been maltreated
• The alleged perpetrator
• Child, as applicable if the child lives separate from the family
• Contractor providing services to the family if the family is receiving services from a CFS contract
• The director of the facility or the child placing agency of a foster home if abuse occurred in a facility or foster home
• Kansas Department of Health and Environment if abuse occurred in a facility or a foster home
The Notice of Department Finding shall be mailed on the same day, or the next working day, as the case finding decision, the date on the Case Finding CFS-2011.

All case decisions/findings shall be staffed with the APS Supervisor/designee and a finding shall be made within (30) working days of receiving the report [K.S.A. 39-1433(a)(3)].

KEESM [12360] allows for joint investigations with KDADS licensed facilities per the option of the DCF Service Center and the facility. Joint investigations require a Memorandum of Agreement between the DCF Service Center and the facility which must be approved by the DCF Central Office APS Attorney. Additionally, the KEESM manual [12230] requires copies of facility based reports be sent to the KDADS Regional Field Staff.

e. **Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

• The state entity or entities responsible for overseeing the operation of the incident management system.

KDADS is the entity responsible for overseeing the operation of the incidence management system called Adverse Incidence Reporting (AIR) system. Kansas Department for Children and Families, Division of Adult Protective Services is responsible for overseeing the reporting of and response to all critical incidents and events related to abuse, neglect and exploitation. Adult Protective Services maintains a data base of all critical incidents/events and makes available the contents of the data base to the Kansas Department for Aging and Disability Services and the Kansas Department of Health and Environment, single state Medicaid agency, on an on-going basis.

• The methods for overseeing the operation of the (AIR) system, including how data are collected, compiled, and used to prevent re-occurrence.
The KDADS Quality Program Manager is responsible for reviewing the incidences reported to AIR and assigning incident to appropriate KDADS field for discovery, follow up and remediation. The Quality Program Manager and the DCF Adult Protective Services Program Manager gather, trend and evaluate data from both sources and report the data to KDADS CSP Director and the State Medicaid Agency.

The KDADS quality team is responsible for reviewing reported critical incidents and events. The data is collected and compiled, trended by waiver population so that it can be analyzed to enable the identification of trends/patterns and the development of quality improvement/ remediation strategies to reduce future occurrence of critical incidents or events.
This information will also be a monitoring, reporting and follow up element of the comprehensive KanCare quality improvement strategy, managed by an Interagency Monitoring Team to support overall quality improvement activities for the KanCare program.

• The frequency of oversight activities.

KDADS conducts on-going, on-site, in-person reviews on a quarterly basis to educate and assess the consumer's knowledge and ability and freedom to prevent or report information about Abuse, Neglect, and Exploitation. If it is determined that there is suspected for Abuse, Neglect or Exploitation, the KDADS Field Staff report immediately. Any areas of vulnerability would be identified for additional training and assurance of education.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

◎ **The State does not permit or prohibits the use of restraints**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

• The state agency (or agencies) responsible for overseeing the use of restraint or seclusion and ensuring that the state's safeguards are followed.

The Kansas Department for Aging and Disability Services (KDADS) has primary responsibility for overseeing this issue, and works with the Kansas Department of Health and Environment (KDHE), as part of the comprehensive KanCare quality improvement strategy to monitor this service issue.

• Methods for detecting unauthorized use, over use or inappropriate, ineffective use of restraint or seclusion and ensuring that all applicable state requirements are followed.

KDADS conducts on-going, on-site, in-person reviews to educate and assess the consumer's knowledge, ability and freedom from the use of restraint or seclusion. If it is determined that there is suspected un-authorized use, the KDADS Field Staff report immediately. Any areas of vulnerability would be identified for additional training and assurance of non-aversive methods.

• How data are analyzed to identify trends and patterns and support improvement strategies; and the methods for overseeing the operation of the incident management system including how data are collected, compiled, and used to prevent re-occurrence.

KDADS Field Staff conduct on-going, on-site, in-person reviews with the consumer and his/her informal supports and paid staff supports to ensure there is no use of restraint or seclusion. Additionally, KDADS Field staff review planning for each individual to ensure appropriate supports and services are in place to eliminate the need for restrictive intervention. On the rare occurrence of detection, the incident is addressed immediately. Any areas of vulnerability would be identified for additional training and assurance of non-aversive methods.

• The frequency of oversight: Continuous and ongoing.

○ **The use of restraints is permitted during the course of the delivery of waiver services.** Complete Items G-2-a-i and G-2-a-ii.

i. **Safeguards Concerning the Use of Restraints.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

◉ **The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

• The state agency (or agencies) responsible for overseeing the use of restrictive interventions and ensuring that the state's safeguards are followed.

The Kansas Department for Aging and Disability Services (KDADS) has primary responsibility for overseeing this issue, and works with the Kansas Department of Health and Environment (KDHE), as part of the comprehensive KanCare quality improvement strategy to monitor this service issue.

• Methods for detecting unauthorized use, over use or inappropriate, ineffective use of restrictive interventions and ensuring that all applicable state requirements are followed.

KDADS conducts on-going, on-site, in-person reviews to educate and assess the consumer's knowledge, ability and freedom from the use of unauthorized restrictive interventions. If it is determined that there is suspected un -authorized use, the KDADS Field Staff report immediately. Any areas of vulnerability would be identified for additional training and assurance of non-aversive methods.

• How data are analyzed to identify trends and patterns and support improvement strategies; and the methods for overseeing the operation of the incident management system including how data are collected, compiled, and used to prevent re-occurrence.

KDADS Field Staff conduct on-going, on-site, in-person reviews with the consumer and his/her informal supports and paid staff supports to ensure there is no use of unauthorized restrictive interventions. Additionally, KDADS Field staff review planning for each individual to ensure appropriate supports and services are in place to eliminate the need for restrictive intervention. On the rare occurrence of detection, the incident is addressed immediately. Any areas of vulnerability would be identified for additional training and assurance of non-aversive methods.

• The frequency of oversight: Continuous and ongoing.

○ **The use of restrictive interventions is permitted during the course of the delivery of waiver services**
Complete Items G-2-b-i and G-2-b-ii.

i. **Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. **Use of Seclusion.** *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

○ **The State does not permit or prohibits the use of seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

○ **The use of seclusion is permitted during the course of the delivery of waiver services.** Complete Items G-2-c -i and G-2-c-ii.

i. **Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. **Applicability.** Select one:

◉ **No. This Appendix is not applicable** *(do not complete the remaining items)*

○ **Yes. This Appendix applies** *(complete the remaining items)*

b. **Medication Management and Follow-Up**

i. **Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

ii. **Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

Answers provided in G-3-a indicate you do not need to complete this section

i. Provider Administration of Medications. *Select one:*

- Not applicable. *(do not complete the remaining items)*
- **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

iii. Medication Error Reporting. *Select one of the following:*

- **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
  Complete the following three items:

  (a) Specify State agency (or agencies) to which errors are reported:

  (b) Specify the types of medication errors that providers are required to *record:*

  (c) Specify the types of medication errors that providers must *report* to the State:

- **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

  Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Health and Welfare**
The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. **Sub-Assurances:**

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of waiver participants who have a disaster red flag designation with a related disaster backup plan N=Number of waiver participants who have a disaster red flag designation with a related disaster backup plan D=Number of waiver participants with a red flag designation

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☑ **Other**	☐ **Annually**	

Specify: KanCare Managed Care Organizations (MCOs)		☑ **Stratified** Describe Group: Proportionate by MCO
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of unexpected deaths for which review/investigation followed the appropriate policies and procedures N=Number of unexpected deaths for which review/investigation followed the appropriate policies and procedures D=Number of unexpected deaths

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
	☐ **Weekly**	☑ **100% Review**

☐ State Medicaid Agency		
☑ Operating Agency	☐ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☐ Representative Sample Confidence Interval =
☑ Other Specify: KanCare Managed Care Organizations (MCOs)	☐ Annually	☐ Stratified Describe Group:
	☑ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☑ State Medicaid Agency	☐ Weekly
☑ Operating Agency	☐ Monthly
☐ Sub-State Entity	☑ Quarterly
☑ Other Specify: KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency	☑ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:

Number and percent of unauthorized uses of restrictive interventions that were appropriately reported N=Number of unauthorized uses of restrictive interventions that were appropriately reported D=Number of unauthorized uses of restrictive interventions

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☑ **Other** Specify: KanCare Managed Care Organizations (MCOs)	☐ **Annually**	☑ **Stratified** Describe Group: Proportionate by MCO
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify:	☑ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of restraint applications, seclusion or other restrictive interventions that followed procedures as specified in the approved waiver N=Number of restraint applications, seclusion or other restrictive interventions that followed procedures as specified in the approved waiver D=Number of restraint applications, seclusion or other restrictive interventions

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☑ **Other** Specify: KanCare Managed Care Organizations (MCOs)	☐ **Annually**	☑ **Stratified** Describe Group: Proportionate by MCO
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☑ State Medicaid Agency	☐ Weekly
☑ Operating Agency	☐ Monthly
☐ Sub-State Entity	☑ Quarterly
☑ Other Specify: KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency	☑ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:
Number and percent of reported critical incidents requiring review/investigation where the State adhered to its follow-up measures N=Number of reported critical incidents requiring review/investigation where the State adhered to its follow-up measures D=Number of reported critical incidents

Data Source (Select one):
Other
If 'Other' is selected, specify:
Critical incident management system

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☑ State Medicaid Agency	☐ Weekly	☑ 100% Review
☑ Operating Agency	☐ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☐ Representative Sample Confidence Interval =
☑ Other Specify:	☐ Annually	☐ Stratified

KanCare Managed Care Organizations (MCOs)		Describe Group:
	☑ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☑ State Medicaid Agency	☐ Weekly
☑ Operating Agency	☐ Monthly
☐ Sub-State Entity	☑ Quarterly
☑ Other Specify: KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency	☑ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:
Number and percent of unexpected deaths for which review/investigation resulted in the identification of preventable causes N=Number of unexpected deaths for which review/investigation resulted in the identification of non-preventable causes D=Number of unexpected deaths

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☐ State Medicaid Agency	☐ Weekly	☑ 100% Review

☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: KanCare Managed Care Organizations (MCOs)	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of participants' reported critical incidents that were initiated and reviewed within required time frames N=Number of participants'

reported critical incidents that were initiated and reviewed within required time frames D=Number of participants' reported critical incidents

Data Source (Select one):
Other
If 'Other' is selected, specify:
Critical incident management system

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: KanCare Managed Care Organizations (MCOs)	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify:	☑ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of waiver participants who received physical exams in accordance with State policies N=Number of HCBS participants who received physical exams in accordance with State policies D=Number of HCBS participants whose service plans were reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Records review

Responsible Party for data	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

collection/generation *(check each that applies):*		
☑ State Medicaid Agency	☐ Weekly	☐ 100% Review
☑ Operating Agency	☐ Monthly	☑ Less than 100% Review
☐ Sub-State Entity	☑ Quarterly	☑ Representative Sample Confidence Interval = 95%
☑ Other Specify: KanCare Managed Care Organizations (MCOs)	☐ Annually	☑ Stratified Describe Group: Proportionate by MCO
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☑ State Medicaid Agency	☐ Weekly
☑ Operating Agency	☐ Monthly
☐ Sub-State Entity	☑ Quarterly
☑ Other Specify: KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency	☑ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:

Number and percent of unexpected deaths for which the appropriate follow-up measures were taken N=Number of unexpected deaths for which the appropriate follow-up measures were taken D=Number of unexpected deaths

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: KanCare Managed Care Organizations (MCOs)	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify:	☑ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of waiver participants who received information on how to report suspected abuse, neglect, or exploitation N=Number of waiver participants who received information on how to report suspected abuse, neglect, or exploitation D=Number of waiver participants interviewed by QMS staff or whose records are reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Record reviews and Customer Interviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☑ **Other** Specify: KanCare Managed Care Organizations (MCOs)	☐ **Annually**	☑ **Stratified** Describe Group: Proportionate by MCO
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☑ State Medicaid Agency	☐ Weekly
☑ Operating Agency	☐ Monthly
☐ Sub-State Entity	☑ Quarterly
☑ Other Specify: KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency	☑ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
Collaboration between the KDADS Field Staff and DCF-APS Social Worker occurs on an on-going basis to review trends and severity of Critical Events. KDADS Field Staff identify trends and severity with PD waiver providers to ensure adequate services and supports are in place. Additionally, KDADS conducts on-going, on-site, in-person reviews to educate and assess the consumer's knowledge and ability and freedom to prevent or report information about Abuse, Neglect, and Exploitation. If it is determined that there is suspected Abuse, Neglect or Exploitation, the KDADS Field Staff report immediately. Any areas of vulnerability would be identified for additional training and assurance of education.

DCF's Division of Adult Protective Services is responsible for overseeing the reporting of and response to all critical incidents and events. Adult Protective Services maintains a data base of all critical incidents/events and makes available the contents of the data base to the KDADS and KDHE on an on-going basis. The Performance Improvement Program Manager of KDADS-Community Services and Programs, and the DCF Adult Protective Services Program Manager, and Children and Family Services gather, trend and evaluate data from multiple sources that is reported to the KDADS-Community Services and Programs Director and the State Medicaid Agency.

These measures and collection/reporting protocols, together with others that are part of the KanCare MCO contract, are included in a statewide comprehensive KanCare quality improvement strategy which is regularly reviewed and adjusted. (The QIS is reviewed at least annually, and adjusted as necessary based upon that review.) That plan is contributed to and monitored through a state interagency monitoring team, which includes program managers, fiscal staff and other relevant staff/resources from both the state Medicaid agency and the state operating agency.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
KDADS-Community Services & Programs is responsible for oversight of critical events/incidents, and unauthorized use of restraints/restrictive procedures, in accordance with Kansas regulatory and statutory requirements. Oversight of regulatory standards and statute is conducted by KDADS Field Staff.

DCF-Child Protective Services (CPS) and DCF-Adult Protective Services (APS) maintain data bases of all critical incidents and events. CPS and APS maintain data bases of all critical incidents and events and make available the contents of the data base to KDADS and KDHE through quarterly reporting.

KDADS and DCF-Child Protective Services (CPS) and DCF-Adult Protective Services (APS) meet on a quarterly basis to trend data, develop evidence-based decisions, and identify opportunities for provider improvement and/or training.

State staff request, approve, and assure implementation of contractor corrective action planning and/or technical assistance to address non-compliance with performance standards as detected through on-site

monitoring, MCO compliance monitoring, survey results and other performance monitoring. These processes are monitored by both contract managers and other relevant state staff, depending upon the type of issue involved, and results tracked consistent with the statewide quality improvement strategy and the operating protocols of the Interagency Monitoring Team.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☑ State Medicaid Agency	☐ Weekly
☑ Operating Agency	☐ Monthly
☐ Sub-State Entity	☑ Quarterly
☑ Other Specify: KanCare Managed Care Organizations (MCOs)	☐ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The Kansas Department of Health and Environment (KDHE), specifically the Division of Health Care Finance, operates as the single State Medicaid Agency, and the Kansas Department for Aging and Disability Services (KDADS) serve as the operating agency. The two agencies collaborate in developing operating agency priorities to meet established HCBS assurances and minimum standards of service.

Through KDADS's Quality Review (QR) process, a statistically significant random sample of HCBS participants is interviewed and data collected for meaningful consumer feedback on the HCBS program. The QR process includes review of participant case files against a standard protocol to ensure policy compliance. KDADS Program Managers regularly communicate with Managed Care Organizations, (MCOs), the functional eligibility contractor and HCBS service providers, thereby ensuring continual guidance on the HCBS service delivery system.

KDADS Quality Review staff collects data based on participant interviews and case file reviews. KDADS Program Evaluation staff reviews, compiles, and analyzes the data obtained as part of the Quality Review process at both the statewide and MCO levels to initiate the HCBS Quality Improvement process. This information is provided quarterly and annually to KDADS management, KDHE's Long-Term Care Committee and Kansas Interagency Monitoring Team (IMT).

In addition to data captured through the QR process, other data is captured within the various State systems, the functional eligibility contractor's systems as well as the Managed Care Organizations' systems. On a routine basis, KDADS' Program Evaluation staff extracts or obtains data from the various systems and aggregates it, evaluating it for any trends or discrepancies as well as any systemic issues. Examples include,

but are not limited to, reports focusing on qualified assessors and claims data.

A third major area of data collection and aggregation focuses on the agency's critical incident management system. KDADS worked with Adult Protective Services (APS), a division within the Kansas Department for Children and Families (formerly the Kansas Department of Social and Rehabilitation Services) and the Managed Care Organizations and established a formal process for oversight of critical incidents and events, including reports generated for trending, the frequency of those reports, as well as how this information is communicated to DHCF-KDHE, the single state Medicaid agency. The system allows for uniform reporting and prevents any possible duplication of reporting to both the MCOs and the State. The Adverse Incident Reporting System, also known as AIR, facilitates ongoing quality improvement to ensure the health and safety of individuals receiving services by agencies or organizations licensed or funded by KDADS and provides information to improve policies, procedures and practices. Incidents are reported within 24 hours of providers becoming aware of the occurrence of the adverse incident. Examples of adverse incidents reported in the system include, but are not limited to, unexpected deaths, medication misuse, abuse, neglect and exploitation.

For all three main areas of data collection and aggregation, KDADS' Program Evaluation staff collects data, aggregates it, analyzes it and provides information regarding discrepancies and trends to Program staff, Quality Review staff and other management staff. If systemic issues are found, several different remediation strategies are utilized, depending upon the nature, scope and severity of the issues. Strategies include, but are not limited to, training of the QR staff to ensure the protocols are utilized correctly, protocol revisions to capture the appropriate data and policy clarifications to MCOs to ensure adherence to policy. Additionally, any remediation efforts might be MCO-specific or provider-specific, again depending on the nature, scope and severity of the issue(s).

WORK PLAN:
The Operating Agency will convene an internal HCBS Quality Improvement Committee, comprised of Program Managers, Quality Review staff, and Program Evaluation Staff, to meet quarterly to evaluate trends reflected in the HCBS HCBSQuality Review Reports and identify areas for improvement beginning April 2014.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Quality Improvement Committee**	☑ **Annually**
☑ **Other** Specify: KanCare Managed Care Organizations (MCOs)	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

The Kansas Department on Aging (KDADS) and the Division of Health Care Finance within the Kansas Department of Health and Environment monitor and analyze the effectiveness of system design changes using several methods, dependent on the system enhancement being implemented. System changes having a direct impact on HCBS participants are monitored and analyzed through KDADS's Quality Review process. Additional questions may be added to the HCBS Customer Interview Protocols to obtain consumer feedback, or additional performance indicators and policy standards may be added to the HCBS Case File Quality Review Protocols. Results of these changes are collected, compiled, reviewed, and analyzed

quarterly and annually.

Based on information gathered through the analysis of the Quality Review data and daily program administration, KDADS Program Managers determine if the issues are systemic or an isolated instance or issue. This information is reviewed to determine if training to a specific Managed Care Organization is sufficient, or if a system change is required.

The Kansas Assessment Management Information System (KAMIS) is the official electronic repository of data about KDADS customers and their received services. This customer-based data is used by KDADS and the MCOs to coordinate activities and manage HCBS programs. System changes are made to KAMIS to enhance the availability of information on participants and performance. Improvements to the KAMIS system are initiated through comments from stakeholders, KDADS Program Managers, and Quality Review staff, and approved and prioritized by KDADS management. Effectiveness of the system design change is monitored by KDADS's Program Managers, working in concert with KDADS's Quality Review and Program Evaluation staff.

DHCF-KDHE contracts with Hewlett Packard (HP) to manage the Medicaid Management Information System (MMIS). Improvements to this system require DHCF-KDHE approval of the concept and prioritization of the change. KDADS staff work with DHCF-KDHE and HP staff to generate recommended systems changes, which are then monitored and analyzed by HP and KDADS to ensure the system change operates as intended and meets the desired performance outcome.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

Following is the process KDADS will use to identify and implement Quality Improvements and periodically evaluate the state's Quality Improvement Strategy:

WORK PLAN:
The Operating Agency will convene an internal HCBS Quality Improvement Committee, comprised of Program, Quality Review, and Program Evaluation Staff, to meet quarterly to evaluate trends reflected in the HCBS HCBSQuality Review Reports and identify areas for improvement beginning April 2014.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Based on signed provider agreements, each HCBS provider is required to permit the Kansas Department of Health and Environment, the Kansas Department for Aging and Disabilities (KDADS), their designee, or any other governmental agency acting in its official capacity to examine any records and documents that are necessary to ascertain information pertinent to the determination of the proper amount of a payment due from the Medicaid program. Additionally, the Division of Legislative Post Audit contracts with an independent accounting firm to complete Kansas' statewide single audit on an annual basis. The accounting firm must comply with all requirements contained in the single audit act. The Medicaid program, including all home and community based services waivers is a required component of the single state audit. Independent audits of the waiver will look at cost-effectiveness, the quality of services, service access, and the substantiation of claims for HCBS payments. These issues are addressed in a variety of ways, including: statewide single annual audit; annual financial and other audits of the KanCare MCOs; encounter data, quality of care and other performance reviews/audits; and audits conducted on HCBS providers. There are business practices of the state that result in additional ongoing audit activities that provide infrastructure/safeguards for the HCBS programs, inculding:
a. Because of other business relationships with the state, each of the following HCBS provider entities are required to obtain and submit annual financial audits, which are reviewed and used to inform their Medicaid business with Kansas: Area Agencies on Aging; Community Mental Health Centers; Community Developmental Disability Organizations; and Centers for Independent Living.
b. As a core provider requirement, FMS providers must obtain and submit annual financial audits, which are reviewed and used to monitor their Medicaid business with Kansas.

Under the KanCare program, payment for services is being made through the monthly pmpm paid by the state to the contracting MCOs. (The payments the MCOs make to individual providers, who are part of their networks and subject to contracting protections/reviewes/member safeguards.) Payments to MCOs are subject to ongoing monitoring and reporting to CMS, consistent with the Special Terms and Conditions issued with approval of the related 1115 waiver. Those STCs include both monitoring of budget neutrality as well as general financial requirements, and also a robust evaluation of that demonstration project which addresses the impact of the KanCare program on access to care, the quality, efficience, and coordination of care, and the cost of care.

In addition, these services - as part of the comprehensive KanCare managed care program - will be part of the corporate compliance/program integrity activities of each of the KanCare MCOs. That includes both monitoring and enforcement of their provider agreements with each provider member of their network and also a robust treatment, consistent with federal regulation and state law requirements, of prevention, detection, intervention, reporting, correction and remediation program related to fraud, waste, abuse or other impropriety in the delivery of Medicaid services under the KanCare program. The activities include comprehensive utilization management, quality data reporting and monitoring, and a compliance officer dedicated to the KanCare program, with a compliance committee that has access to MCO senior management. As those activities are implemented and outcomes achieved, the MCOs will be providing regular and ad hoc reporting of results. KDHE will have oversight of all portions of the program and the KanCare MCO contracts, and will collaborate with KDADS regarding HCBS program management, including those items that touch on financial integrity and corporate compliance/program integrity. The key component of that collaboration will be through the KanCare Interagency Monitoring Team, an important part of the overall state's KanCare Quality Improvement Strategy, which will provide quality review and monitoring of all aspects of the KanCare program – engaging program management, contract management, and financial management staff from both KDHE and KDADS.

Some of the specific contractual requirements associated with the program integrity efforts of each MCO include:

Coordination of Program Integrity Efforts.
The CONTRACTOR shall coordinate any and all program integrity efforts with KDHE/DHCF personnel and Kansas' Medicaid Fraud Control Unit (MFCU), located within the Kansas Attorney General's Office. At a minimum, the CONTRACTOR shall:
a. Meet monthly, and as required, with the KDHE/DHCF staff and MFCU staff to coordinate reporting of all instances of credible allegations of fraud, as well as all recoupment actions taken against providers;
b. Provide any and all documentation or information upon request to KDHE/DHCF or MFCU related to any aspect of this contract, including but not limited to policies, procedures, subcontracts, provider agreements, claims data, encounter data, and reports on recoupment actions and receivables;
c. Report within two (2) working days to the KDHE/DHCF, MFCU, and any appropriate legal authorities any evidence indicating the possibility of fraud and abuse by any member of the provider network; if the CONTRACTOR fails to report any suspected fraud or abuse, the State may invoke any penalties allowed under this contract including, but not limited to, suspension of payments or termination of the contract. Furthermore, the enforcement of penalties under the contract shall not be construed to bar other legal or equitable remedies which may be available to the State or MFCU for noncompliance with this section;
d. Provide KDHE/DHCF with a quarterly update of investigative activity, including corrective actions taken;
e. Hire and maintain a staff person in Kansas whose duties shall be composed at least 90% of the time in the oversight and management of the program integrity efforts required under this contract. This person shall be designated as the Program Integrity Manager. The program integrity manager shall have open and immediate access to all claims, claims processing data and any other electronic or paper information required to assure that program integrity activity of the CONTRACTOR is sufficient to meet the requirements of the KDHE/DHCF. The duties shall include, but not be limited to the following:
(1) Oversight of the program integrity function under this contract;
(2) Liaison with the State in all matters regarding program integrity;
(3) Development and operations of a fraud control program within the CONTRACTOR claims payment system;
(4) Liaison with Kansas' MFCU;
(5) Assure coordination of efforts with KDHE/DHCF and other agencies concerning program integrity issues.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Financial Accountability**
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. **Sub-Assurances:**

a. ***Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.*** *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of provider claims that are coded and paid in accordance with the state's approved reimbursement methodology N=Number of provider claims that are coded and paid in accordance with the state's approved reimbursement methodology D=Total number of provider claims paid

Data Source (Select one):
Other
If 'Other' is selected, specify:
DSS/DAI encounter data

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: KanCare Managed Care Organizations (MCOs)	☐ **Annually**	☐ **Stratified** Describe Group:
		☐ **Other**

	☐ **Continuously and Ongoing**	Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of clean claims that are paid by the managed care organizations within the timeframes specified in the contract N=Number of clean claims that are paid by the managed care organizations within the timeframes specified in the contract D=Total number of provider claims

Data Source (Select one):
Other
If 'Other' is selected, specify:
DSS/DAI encounter data

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample**

		Confidence Interval =
☑ **Other** Specify: KanCare Managed Care Organizations (MCOs)	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of payment rates that were certified to be actuarially sound by the State's actuary and approved by CMS N=number of payment rates that were certified to be actuarially sound by the State' actuary and approved by CMS D=Total number of capitation (payment) rates

Data Source (Select one):
Other
If 'Other' is selected, specify:
Rate-setting documentation

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☑ State Medicaid Agency	☐ Weekly	☑ 100% Review
☐ Operating Agency	☐ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☐ Representative Sample Confidence Interval =
☐ Other Specify:	☑ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
☑ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☐ Other Specify:	☑ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*

b. ***Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The state established a KanCare Interagency Coordination and Contract Monitoring (KICCM) to ensure effective interagency coordination as well as overall monitoring of MCO contract compliance. This work will be governed by the comprehensive state Quality Improvement Strategy for the KanCare program, a key component of which is the Interagency Monitoring Team that engages program management, contract management and financial management staff of both KDHE and KDADS.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
These measures and collection/reporting protocols, together with others that are part of the KanCare MCO contract, are included in a statewide comprehensive KanCare quality improvement strategy which is regularly reviewed and adjusted. That plan is contributed to and monitored through a state interagency monitoring team, which includes program managers, contract managers, fiscal staff and other relevant staff/resources from both the state Medicaid agency and the state operating agency.
State staff request, approve, and assure implementation of contractor corrective action planning and/or technical assistance to address non-compliance with performance standards as detected through on-site monitoring, survey results and other performance monitoring. These processes are monitored by both contract managers and other relevant state staff, depending upon the type of issue involved, and results tracked consistent with the statewide quality improvement strategy and the operating protocols of the Interagency Monitoring Team.

ii. **Remediation Data Aggregation**

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*
☑ State Medicaid Agency	☐ Weekly
☑ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☑ Other Specify:	☐ Annually

Responsible Party*(check each that applies)*:	Frequency of data aggregation and analysis *(check each that applies)*:
KanCare MCOs contracting with Kansas.	
	☑ Continuously and Ongoing
	☐ Other Specify:

c. **Timelines**
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

◉ **No**

○ **Yes**
Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. **Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Under the KanCare comprehensive managed care program, capitation rates are established consistent with federal regulation requirements, by actuarially sound methods, which take into account utilization, medical expenditures, program changes and other relevant environmental and financial factors. The resulting rates are certified to and approved by CMS.

b. **Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Claims for services are submitted to the MCOs directly from waiver provider agencies or from Financial Management Service (FMS) agencies for those individuals self-directing their services. All claims are either submitted through the EVV system, the State's front end billing solution or directly to the MCO either submitted through paper claim format or through electronic format. Claims for services required in the EVV system are generated from that system. Capitated payments in arrears are made only when the consumer was eligible for the Medicaid waiver program during the month.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. **Certifying Public Expenditures** *(select one)*:

◉ **No. State or local government agencies do not certify expenditures for waiver services.**

○ **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

Select at least one:

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. **Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

A capitated payment is made to the MCOs for each month of Waiver eligibility. This is identified through KAECES, the State's eligibility system. The state also is requiring the MCOs to utilize the State's contracted Electronic Visit Verification for mandatory Waiver services. Those Waiver services are billed through EVV based on electronically verified provided services, connected to the consumer's plan of care detailing authorized services. All mandated services must be billed through the EVV system. Reviews to validate that services were in fact provided as billed is part of the financial integrity reviews described above in Section I-1.

e. **Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. **Method of payments -- MMIS** (*select one*):

○ **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**

○ **Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ **Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

◎ **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

The MMIS Managed Care system assigns beneficiaries to one of the three KanCare Plans. Each assignment generates an assignment record, which is shared with the plans via an electronic record. At the end of each month, the MMIS Managed Care System creates a capitation payment, paid in arrears, for each beneficiary who was assigned to one of the plans. Each payment is associated to a rate cell. The rate cells, defined by KDHE as part of the actuarial rate development process which is certified to and approved by CMS, each have a specific dollar amount established by actuarial data for a specific cohort and an effective time period for the rate.

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. **Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

☐ **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**

☐ **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**

☐ **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☑ **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

All of the waiver services in this program are included in the state's contract with the KanCare MCOs.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. **Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

◎ **No. The State does not make supplemental or enhanced payments for waiver services.**

○ **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to State or Local Government Providers. *Specify whether State or local government providers receive payment for the provision of waiver services.*

◉ **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.

○ **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

Answers provided in Appendix I-3-d indicate that you do not need to complete this section.

○ **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**

○ **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**

○ **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. **Provider Retention of Payments.** Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

No. The monthly capitated payments to the MCOs are not reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. **Additional Payment Arrangements**

i. **Voluntary Reassignment of Payments to a Governmental Agency.** *Select one:*

- **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. **Organized Health Care Delivery System.** *Select one:*

- **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. **Contracts with MCOs, PIHPs or PAHPs.** *Select one:*

- **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive**

waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

◎ **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. **State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

☐ **Appropriation of State Tax Revenues to the State Medicaid agency**

☑ **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I -2-c:

The non-federal share of the waiver expenditures is from direct state appropriations to the Department for Aging and Disability Services (KDADS), through agreement with the Single State Medicaid Agency, Kansas Department of Health and Environment(KDHE), as of July 1, 2012. The non-federal share of the waiver expenditures are directly expended by KDADS. Medicaid payments are processed by the State's fiscal agent through the Medicaid Management Information System using the InterChange STARS Interface System (iCSIS). iCSIS contains data tables with the current federal and state funding percentages for all funding types. State agencies are able to access iCSIS's reporting module to identify payments made by each agency. KDHE – Division of Health Care Finance draws down federal Medicaid funds for all agencies based on the summary reports from iCSIS. Interfund transfers to the other state agencies are based on finalized fund summary reports. The full rate will be expended on capitation payments in the KanCare program.

☐ **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. **Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

◎ **Not Applicable.** There are no local government level sources of funds utilized as the non-federal share.

○ **Applicable**
Check each that applies:

☐ **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. **Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

◉ **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**

○ **The following source(s) are used**

Check each that applies:

☐ **Health care-related taxes or fees**

☐ **Provider-related donations**

☐ **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. **Services Furnished in Residential Settings.** *Select one:*

○ **No services under this waiver are furnished in residential settings other than the private residence of the individual.**

◉ **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. **Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

When establishing reimbursement rates as described in Appendix I-2,a, no expenses associated with room and board are considered.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ◉ **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- ○ **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C -3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. **Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- ◉ **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- ○ **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. **Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

***Charges Associated with the Provision of Waiver Services** (if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- ☐ **Nominal deductible**
- ☐ **Coinsurance**
- ☐ **Co-Payment**
- ☐ **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. **Co-Payment Requirements.**

ii. **Participants Subject to Co-pay Charges for Waiver Services.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. **Co-Payment Requirements.**

iii. **Amount of Co-Pay Charges for Waiver Services.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. **Co-Payment Requirements.**

iv. **Cumulative Maximum Charges.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. **Other State Requirement for Cost Sharing.** Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

◉ **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**

○ **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	18350.61	9151.60	27502.21	40485.32	3064.35	43549.67	16047.46
2	18442.23	9228.08	27670.31	41508.84	3105.13	44613.97	16943.66
3	18535.55	9307.09	27842.64	42558.24	3146.60	45704.84	17862.20
4	18628.03	9387.65	28015.68	43634.17	3188.75	46822.92	18807.24
5	18723.43	9469.79	28193.22	44737.29	3234.61	47971.90	19778.68

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. **Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		Nursing Facility
Year 1	7092	7092
Year 2	7092	7092
Year 3	7092	7092
Year 4	7092	7092
Year 5	7092	7092

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. **Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

Average Length of Stay was calculated by using the total days of waiver coverage for CY2013 (1/1/2013 - 12/31/2013) : 2,331,467, divided by the unduplicated number eligible: 7,092, or 329 ALOS.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. **Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

i. **Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

Factor D was estimated by utilizing data from the Kansas MMIS system and reflects the average HCBS waiver service cost and utilization for PD waiver participants for the calendar year 2013. This average expenditure was projected to Years 1 through 5 of the waiver with the assumption that these services would be provided under a managed care delivery system. Annual expenditures were projected at an average annual trend of 0.5%.

ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' was estimated by utilizing data from the Kansas MMIS system and reflects the average acute care cost and utilization for PD waiver participants
for the calendar year 2013. This average expenditure was projected to Years 1 through 5 of the waiver with the assumption that these services would be provided under a managed care delivery system. Annual expenditures were projected at an average annual trend of 0.85%.

Factor D' does not include the cost of Medicare Part D Prescribed Drugs. This is not a Medicaid cost and is not paid through the MMIS system.

iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G was estimated by utilizing data from the Kansas MMIS system and reflects the average nursing facility cost and utilization for nursing facility members for the calendar year 2013. This average expenditure was projected to Years 1 through 5 of the waiver with the assumption that these services would be provided under a FFS delivery system. Annual expenditures were projected at an average annual trend of 2.5%.

iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G' was estimated by utilizing data from the Kansas MMIS system and reflects the average acute care cost and utilization for nursing facility members for the calendar year 2013. This average expenditure was projected to Years 1 through 5 of the waiver with the assumption that these services would be provided under a FFS delivery system. Annual expenditures were projected at an average annual trend of 1.3%.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services	
Personal Care Services	
Financial Management Services	
Assistive Services	
Home-Delivered Meals Service	
Medication Reminder Services	
Personal Emergency Response System and Installation	
Sleep Cycle Support	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J -1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Care Services Total:							107687808.51
Personal Services - Agency-Directed	☑	1 unit = 15 minutes	1360	3957.36	3.17	17060970.43	
Personal Services - Self-Directed	☑	1 unit = 15 minutes	6090	5295.82	2.81	90626838.08	
Financial Management Services Total:							7157780.11
Financial Management Services	☑	1 unit = 1 month	6172	10.11	114.71	7157780.11	
Assistive Services Total:							105647.34
Assistive Services	☑	1 unit = 1 purchase	69	1.18	1297.56	105647.34	
Home-Delivered Meals Service Total:							2534830.88
Home-Delivered Meals Service	☑	1 unit = 1 meal	1539	301.66	5.46	2534830.88	
Medication Reminder Services Total:							25423.74
Medication Reminder/Dispenser/Installation	☑	1 unit = 1 month	6	2.69	15.91	256.79	
Medication Reminder	☑	1 unit = 1 month	171	5.30	25.39	23010.96	
Medication Reminder/Dispenser	☑	1 unit=1 installation	44	1.96	25.00	2156.00	
Personal Emergency Response System and Installation Total:							1019005.55
Personal Emergency Response System	☑	1 unit = 1 month	3227	9.10	34.16	1003132.31	
Personal Emergency Response System Installation	☑	1 unit=1 installation	301	1.06	49.75	15873.24	
Sleep Cycle Support Total:							11611999.24
Sleep Cycle Support	☑	1 unit=1 sleep cycle	1641	233.46	30.31	11611999.24	
					GRAND TOTAL:		130142495.37
					Total: Services included in capitation:		130142495.37
					Total: Services not included in capitation:		
					Total Estimated Unduplicated Participants:		7092
					Factor D (Divide total by number of participants):		18350.61
					Services included in capitation:		18350.61
					Services not included in capitation:		
					Average Length of Stay on the Waiver:		329

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component

Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J -1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Care Services Total:							108226276.75
Personal Services - Agency-Directed	☑	1 unit = 15 minutes	1360	3977.15	3.17	17146289.08	
Personal Services - Self-Directed	☑	1 unit = 15 minutes	6090	5322.30	2.81	91079987.67	
Financial Management Services Total:							7193179.62
Financial Management Services	☑	1 unit = 1 month	6172	10.16	114.71	7193179.62	
Assistive Services Total:							106542.65
Assistive Services	☑	1 unit = 1 purchase	69	1.19	1297.56	106542.65	
Home-Delivered Meals Service Total:							2547519.32
Home-Delivered Meals Service	☑	1 unit = 1 meal	1539	303.17	5.46	2547519.32	
Medication Reminder Services Total:							25522.53
Medication Reminder/Dispenser/Installation	☑	1 unit = 1 installatio	44	1.97	25.00	2167.00	
Medication Reminder	☑	1 unit = 1 month	6	2.70	15.91	257.74	
Medication Reminder/Dispenser	☑	1 unit = 1 month	171	5.32	25.39	23097.79	
Personal Emergency Response System and Installation Total:							1023564.67
Personal Emergency Response System	☑	1 unit = 1 month	3227	9.14	34.16	1007541.68	
Personal Emergency Response System Installation	☑	1 unit=1 installation	301	1.07	49.75	16022.98	
Sleep Cycle Support Total:							11669696.14
Sleep Cycle Support	☑	1 unit=1 sleep cycle	1641	234.62	30.31	11669696.14	

GRAND TOTAL:	130792301.68
Total: Services included in capitation:	130792301.68
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	7092
Factor D (Divide total by number of participants):	18442.23
Services included in capitation:	18442.23
Services not included in capitation:	
Average Length of Stay on the Waiver:	329

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J -1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Care Services Total:							108767571.92
Personal Services - Agency-Directed	☑	1 unit = 15 minutes	1360	3997.04	3.17	17232038.85	
Personal Services - Self-Directed	☑	1 unit = 15 minutes	6090	5348.92	2.81	91535533.07	
Financial Management Services Total:							7235659.03
Financial Management Services	☑	1 unit = 1 month	6172	10.22	114.71	7235659.03	
Assistive Services Total:							107437.97
Assistive Services	☑	1 unit = 1 purchase	69	1.20	1297.56	107437.97	
Home-Delivered Meals Service Total:							2560291.79
Home-Delivered Meals Service	☑	1 unit = 1 meal	1539	304.69	5.46	2560291.79	
Medication Reminder Services Total:							25664.74
Medication Reminder/Dispenser/Installation	☑	1 unit = 1 installatior	44	1.98	25.00	2178.00	
Medication Reminder	☑	1 unit = 1 month	6	2.71	15.91	258.70	
Medication Reminder/Dispenser	☑	1 unit = 1 month	171	5.35	25.39	23228.04	
Personal Emergency Response System and Installation Total:							1029076.38
Personal Emergency Response System	☑	1 unit = 1 month	3227	9.19	34.16	1013053.40	
Personal Emergency Response System Installation	☑	1 unit=1 installation	301	1.07	49.75	16022.98	
Sleep Cycle Support Total:							11728387.82
Sleep Cycle Support	☑	1 unit=1 sleep cycle	1641	235.80	30.31	11728387.82	

GRAND TOTAL:	131454089.64
Total: Services included in capitation:	131454089.64
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	7092
Factor D (Divide total by number of participants):	18535.55
Services included in capitation:	18535.55
Services not included in capitation:	
Average Length of Stay on the Waiver:	329

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J -1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Care Services Total:							109311308.64
Personal Services - Agency-Directed	☑	1 unit = 15 minutes	1360	4017.02	3.17	17318176.62	
Personal Services - Self-Directed	☑	1 unit = 15 minutes	6090	5375.66	2.81	91993132.01	
Financial Management Services Total:							7271058.53
Financial Management Services	☑	1 unit = 1 month	6172	10.27	114.71	7271058.53	
Assistive Services Total:							107437.97
Assistive Services	☑	1 unit = 1 purchase	69	1.20	1297.56	107437.97	
Home-Delivered Meals Service Total:							2573064.26
Home-Delivered Meals Service	☑	1 unit = 1 meal	1539	306.21	5.46	2573064.26	
Medication Reminder Services Total:							25807.90
Medication Reminder/Dispenser/Installation	☑	1 unit = 1 installatio	44	1.99	25.00	2189.00	
Medication Reminder	☑	1 unit = 1 month	6	2.73	15.91	260.61	
Medication Reminder/Dispenser	☑	1 unit = 1 month	171	5.38	25.39	23358.29	
Personal Emergency Response System and Installation Total:							1034737.85
Personal Emergency Response System	☑	1 unit = 1 month	3227	9.24	34.16	1018565.12	
Personal Emergency Response System Installation	☑	1 unit=1 installation	301	1.08	49.75	16172.73	

GRAND TOTAL:	132109997.25
Total: Services included in capitation:	132109997.25
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	7092
Factor D (Divide total by number of participants):	18628.03
Services included in capitation:	18628.03
Services not included in capitation:	
Average Length of Stay on the Waiver:	329

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Sleep Cycle Support Total:							11786582.11
Sleep Cycle Support	☑	1 unit=1 sleep cycle	1641	236.97	30.31	11786582.11	

GRAND TOTAL:	132109997.25
Total: Services included in capitation:	132109997.25
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	7092
Factor D (Divide total by number of participants):	18628.03
Services included in capitation:	18628.03
Services not included in capitation:	
Average Length of Stay on the Waiver:	329

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J -1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Care Services Total:							109875028.30
Personal Services - Agency-Directed	☑	1 unit = 15 minutes	1360	4037.11	3.17	17404788.63	
Personal Services - Self-Directed	☑	1 unit = 15 minutes	6090	5403.54	2.81	92470239.67	
Financial Management Services Total:							7306458.04
Financial Management Services	☑	1 unit = 1 month	6172	10.32	114.71	7306458.04	
Assistive Services Total:							108333.28
Assistive Services	☑	1 unit = 1 purchase	69	1.21	1297.56	108333.28	
Home-Delivered Meals Service Total:							2585920.76
Home-Delivered Meals Service	☑	1 unit = 1 meal	1539	307.74	5.46	2585920.76	
Medication Reminder Services Total:							25906.69

GRAND TOTAL:	132786565.46
Total: Services included in capitation:	132786565.46
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	7092
Factor D (Divide total by number of participants):	18723.43
Services included in capitation:	18723.43
Services not included in capitation:	
Average Length of Stay on the Waiver:	329

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Medication Reminder/Dispenser/Installation	☑	1 unit = 1 installation	44	2.00	25.00	2200.00	
Medication Reminder	☑	1 unit = 1 month	6	2.74	15.91	261.56	
Medication Reminder/Dispenser	☑	1 unit = 1 month	171	5.40	25.39	23445.13	
Personal Emergency Response System and Installation Total:							1039147.22
Personal Emergency Response System	☑	1 unit = 1 month	3227	9.28	34.16	1022974.49	
Personal Emergency Response System Installation	☑	1 unit=1 installation	301	1.08	49.75	16172.73	
Sleep Cycle Support Total:							11845771.17
Sleep Cycle Support	☑	1 unit=1 sleep cycle	1641	238.16	30.31	11845771.17	

GRAND TOTAL:	132786565.46
Total: Services included in capitation:	132786565.46
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	7092
Factor D (Divide total by number of participants):	18723.43
Services included in capitation:	18723.43
Services not included in capitation:	
Average Length of Stay on the Waiver:	329